Mental Health Associates

REGISTRATION
(Please Print)

Date: _____

Cell # (____) _____ Home # (____) _____ Email Address: _____

DOB: ____/____/____ Social Security #: _____

Sex: ____Male ____Female
____ Transgender Male (M to F)
____ Transgender Female (F to M)
____ Genderqueer
____ Other ____Decline

Patient: _____
FIRST MI LAST

Preferred Name: _____

Address: _____

_____
CITY STATE ZIP

Marital Status:

____ Single ____ Married
____ Widowed ____ Separated
____ Divorced

P.O. Box: _____ Occupation: _____

Patient Employer: _____ Employer Phone #: _____

Employer Address: _____
CITY STATE ZIP

Spouse/Parent: _____ DOB: ____/____/____ SSN#: _____

Address: _____
CITY STATE ZIP

Phone #: _____ Employer & Phone#: _____

Other Parent: _____ DOB: ____/____/____ SSN#: _____

Address: _____
CITY STATE ZIP

Phone #: _____ Employer & Phone#: _____

Primary Insurance: _____

ID#: _____

Policy Holder Name: _____

DOB: ____/____/____

Secondary Insurance: _____

ID#: _____

Policy Holder Name: _____

DOB: ____/____/____

Primary Care Physician: _____

Whom Referred you: _____

*2212 Pierce St. Suite 100 * Sioux City, IA 51104 * 712-255-8323 * Fax 712-255-8287*

Mental Health Associates

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with

_____

Name of Insurance Company/Companies/EAP Company

and assign directly to Mental Health Associates, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor or therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ Date _____

Signature of Client or Personal Representative

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Mental Health Associates, LLC for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests payments be made and authorizes release of medial information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the doctor, therapist, or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ Date _____

Signature of Client or Personal Representative

SOCIAL SECURITY DISABILITY

I, the undersigned, authorize Social Security Disability to pay for any services that have been authorized by Social Security Disability.

_____ Date _____

Signature of Client or Personal Representative

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Mental Health Associates

MISSED APPOINTMENTS POLICY

Appointments are scheduled in advance so that your therapist can prepare and make the best use of your therapy time. When you cannot attend a scheduled session, you must call no later than the end of the preceding business day (5:00 p.m.) and cancel.

Appointments that you miss without calling ahead to cancel or miss altogether are very inconvenient and costly. Barring illness or other emergencies, appointments that are not cancelled appropriately will be billed $55 for the social workers and $62.50 for the psychologists.

If there are 3 unexcused missed appointments in a 6-month span of time; your therapist or psychologist can use their discretion to dismiss you from our clinic. A dismissal letter will be forwarded to you with a list of other providers with whom you could schedule an appointment.

Your cooperation and consideration in this matter is very much appreciated. It is important to remember that charges for missed or late cancelled appointments cannot be billed to your insurance carrier and must be paid solely by you.

I have read and understand the above policy.

Signature of Client or Personal Representative Date

TERMINATION POLICY

Clients who have not had a session in over 60 days (or within a mutually agreed upon time) will be considered inactive. It is always preferred to schedule a final session before ending therapy in order to review and evaluate the sessions and assess overall progress. Please be fully assured that anyone wishing to return to active therapy can do so by contacting the office to make arrangements to resume the therapeutic relationship.

Your signature below indicates that you have read this agreement and agree to its terms.

Signature of Client or Personal Representative Date

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Mental Health Associates

Authorization, Consent, & Acknowledgement

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Mental Health Associates, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Mental Health Associates, LLC.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Mental Health Associates, LLC is not required to agree to the restrictions that I may request. However, if Mental Health Associates, LLC agrees to a restriction that I request, the restriction is binding on Mental Health Associates, LLC. I have the right to revoke this consent, in writing at any time, except to the extent that Mental Health Associates, LLC has taken action in reliance on this consent.

I understand I may request a copy of the *Notice of Patient Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Patient Privacy Practices* from time to time and that I may contact Mental Health Associates, LLC at any time at the address above to obtain a current copy of the *Notice of Patient Privacy Practices.*

Coordination of Treatment

☐ I give permission for my provider at Mental Health Associates, LLC to release mental health information for the purpose of coordination of care with my primary care physician and any other medical practitioners who provide care for me. *(If you check this box, please include these person/persons on the release of information)*

☐ I decline to release information to my primary care physician or other medical providers at this time

Advance Directives (Living Will)

☐ I currently have a Psychiatric Advance Directive.

☐ I do not have a Psychiatric Advance Directive. I understand I can follow up on this by logging on to www.nrc-pad.org . It is recommended that you seek legal counsel when completing this document. If such a document is completed, I will provide a copy to this office.

Print Patient Name _____

Relationship to Patient _____

_____

Signature of Client or Personal Representative Date

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Adult Information Form

CONFIDENTIAL

Note

The information you disclose on this form is for use by the provider to aid in better understanding your problems and developing an appropriate treatment plan for you. This information will not be released to any other parties without your explicit consent or very exceptional circumstances. If you have any concerns about this, please discuss this with the provider.

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Sex: _____ Place of Birth: _____ SSN#: _____

Marital Status: _____ Single _____ Married _____ Divorced

_____ Separated _____ Widowed _____ Cohabitating

Client's Race: _____

RESIDENCE:

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home (___) _____ Work (___) _____

Emergency Contact: _____ Relation to Client: _____

Phone: _____ Address: _____

EDUCATION: **AVERAGE GRADES:** _____

School(s) Location(s) Dates

_____

_____

_____

Problem Areas in School:

_____

_____

_____

EMPLOYMENT: Where How long worked

_____

_____

_____

_____

_____

By Whom Were You Referred? _____

SPOUSE AND CHILDREN:

Names Sex Age Relationship to Client

(Place a check by those living in the home)

IMPORTANT PEOPLE:

Name Age Education Occupation Comments (e.g. Health)

Father:

Mother:

Sibling:

Sibling:

Sibling:

Other Important People: (Friends, coworkers, Etc.)

MEDICAL:

Physician: Name, Address & Phone:

Date Last Seen: Last Physical:

Current and/or Chronic Medical Problems/Diseases/Conditions/Etc.: ☐ None

Allergies: ☐ None

Current prescription medications/dosage/start dates: ☐ None

Hospitalizations/Surgeries (include dates, outcomes): ☐ None

PREVIOUS COUNSELING, PSYCHOTHERAPY, SUBSTANCE ABUSE OR OTHER MENTAL HEALTH SERVICES:

Names Profession City Dates Type

SUBSTANCE ABUSE HISTORY:

Substance	Amount	Frequency	Duration	1st Used	Last Used
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Other					

CLIENT'S DEVELOPMENT:

Developmental History (developmental milestones met early, late or normal):

Peri-natal History (details of labor/delivery, problems, normal delivery, premature birth, etc):

Prenatal History (problems encountered during pregnancy):

CONCERNS AND MISCELLANEOUS:

What are your main concerns?

COMMENTS: (Please provide any other information about yourself which may be helpful to us in understanding the situation. If you need more room please use the backside of this paper):