Patient Registration/Patient Rights and Responsibilities

Please fill out this form, read the *Patient Rights and Responsibilities* (on the back of this form), and sign where indicated.

Today's date:_____

Patient Information:

Soc Sec #:_____ Marital Status: S M S-O Sep Div Wid Date of Birth:_____ Age:____

Last Name:_____ First Name:_____ M.I.:_____

Address:_____ Mailing Address (if different)_____

City:_____ County: _____ State: NC Zip Code:_____

Drivers License #:_____ E-Mail Address: _____ Home Phone:_____

Work Phone:_____ Cell Phone:_____ May I call at Home?_____

Employer Name:_____ Address:_____

Spouse's/S-O Name:_____ Sp/S-O Employer:_____ Sp/S-O DOB:_____

Referred By: Insurance, Doctor, EAP, Self, Other (circle one) Referral Name:_____

If You Are A Dependent, Complete The Following:

Both Parents Names:_____

School Name:_____ Address:_____ Grade:_____

Insurance Information: (Please give your insurance card to the counselor)

Primary Insurance Co:_____ Group Number: _____ Member ID:_____

Auth. #:_____ Deductible: $_____ Co-payment: $_____

Primary Care Physician:_____ Group_____

Office Phone No:_____ Address_____

Medications Prescribed:_____

State The Reason You Are Here Today:_____

Are you required by your school, your employer, a judge, or a probation officer to have this appointment? Yes No

Is this problem related to an accident or injury? Yes No Is it work related? Yes No

Prior Treatment History:

Psychiatric Inpatient? Yes No Psychiatric Outpatient? Yes No

Substance Abuse Inpatient? Yes No Substance Outpatient? Yes No

Name(s) of Facilities where have you been hospitalized:_____

I certify that the above information is correct and that I have read and undersigned the *Patient Rights and Responsibilities* on the back of this form. I understand that payment is to be made at the time of the session, and that I am financially responsible for all schedule appointments unless a minimum of 24 hours notice is given. I also authorize my **Insurer** and/or **Counselor** to release my treatment records, as required, to my primary care physician (if an HMO patient). This release will terminate one year from my last appointment unless a written notice for extension is given.

I understand that Debit and Credits Cards are NOT ACCEPTED for payment; that Cash or personal checks are acceptable for payment and is expected at the beginning of each session.

Patient Signature:_____ Date:_____

Witness or co-patient:_____ Date:_____

Patient Rights and Responsibilities

1. Patient Relations

All patients have the right to be treated in a courteous, considerate, and dignified manner. If you have any issue that cannot be resolved with your clinician, please call your insurance case manager or patient relations representative at your local insurance office. If you are not satisfied with results at the local office, call your insurance's corporate patient relations staff at the number[s] listed on your insurance card or in your insurance benefits package.

2. Confidentiality

Privacy and confidentiality are of the utmost importance to the clinical relationship. Please feel free to discuss the legal limitations of confidentiality with your clinician. Your insurance is legally required to carry out quality assurance practices, and, under some managed care plans, your insurance will provide your primary care physician with information related to your case. Your insurance will follow these procedures unless otherwise notified by you, in writing.

Should your insurance or any of its constituents be subpoenaed, you clinician will normally provide the requested information, whether or not the information is favorable to the undersigned. In the event of subpoena or attorney's request, it is fully understood that your clinician *will* charge the patient up to **$100.00** per hour for reports, court appearance(s), travel or any costs not reimbursed by insurance companies.

3. Financial

Patients are responsible for payment of all applicable fees at the time of the session. If you are a parent or guardian of a minor patient, all costs not covered by their insurance company will be your responsibility. The charge for your initial assessment is **$85.00** and **$85.00** for each additional session. Sessions are **fifty (50) minutes** in duration. Payment at the beginning of each session is preferred. **Cash or personal checks are acceptable for payment. Debit and Credits Cards are NOT accepted for payment**. Your clinician will provide you with a receipt at the conclusion of each session and for each payment. If your clinician is providing services to you through your Employee Assistance Program, he will follow the service agreement specific to your EAP.

Managed Care Patients

Patients are responsible for payment of co-pays at the time of the session. If you miss more than two co-payments, your eligibility for insurance authorized outpatient services may be jeopardized. If you are unable to pay, please discuss this with your clinician and/or insurance case manager. If you exhaust your benefit, you may make private arrangements with your clinician to continue care of, or ask him/her, or your insurance, to make alternate arrangements.

4. Appointments

Your insurance and your clinician will make every effort to arrange appointment times that are convenient for you. Specific hours vary, but generally are during normal business hours. Appointments at other times are available for special needs.

In the event that you must cancel an appointment, please call your clinician at least 24 hours in advance. Failure to give adequate notice may result in your being billed for the appointment.

5. Authorization for Services - Managed Care Plans

In accordance with your insurance plan, your insurance must pre-approve all mental health and chemical dependency services. Non-compliance could lead to denial of benefits. Insurance approved clinicians, facilities and hospitals, must provide outpatient and inpatient services. Calling your insurance from 9:00 A.M. to 5:00 P.M., Monday through Friday can arrange for routine services. Calling your insurance, 24 hours per day, 7 days per week, can access emergency services.

6. Exclusions

Some insurance plans do not cover involuntary or court-ordered treatment. Psychological testing may or may not be covered under your insurance plan. Services generally not covered include: 1.) Psychological/Educational testing for children requested by or for a school system to assist a child in his or her emotional or academic development; 2.) Any psychological services required for fulfilling a legal evaluation. Exclusions include testing, report writing, counseling and psychotherapy or court testimony including evaluations in criminal, domestic and custody situations, as well as situations involving psychological injury where there is civil litigation; 3.) Developmental disabilities; 4.) Career or vocational testing; and 5.) Testing as required by law to fulfill certain job requirements such as those for police or security guards. Testing or therapy not covered by insurance can be arranged for privately. Please consult your clinician.

*Signature*_____ *Date*_____

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

List reasons for this appointment
List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No

Do you have vision or hearing loss?	☐ Yes	☐ No
Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Spouse	☐ M ☐ F			☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
Sibling	☐ M ☐ F		**Grandmother** *Maternal*		
Sibling	☐ M ☐ F		**Grandfather** *Maternal*		
Sibling	☐ M ☐ F		**Grandmother** *Paternal*		
Sibling	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

OTHER PROBLEMS

Describe any symptoms or conditions not addressed above and briefly explain.

SUBSTANCE USE HISTORY

Patient Name	Social Security No.	Date

Address	Phone No.

PATTERNS OF USE

	PAST HISTORY		*PRESENT HISTORY*		
Types of Chemicals Used	Age of First Use	Pattern / Dose & Frequency	Current Pattern / Dose & Frequency	Usual Route of Administration	Last Use-Date
Alcohol					
Cannabis					
Cocaine / Crack					
Heroin					
Narcotics					
Tranquilizers					
Amphetamines					
Inhalants					
Other					

PHYSICAL SIGNS AND SYMPTOMS

Is patient experiencing the following at present?

☐ Staggering gait	☐ Nervousness	☐ Nausea	☐ Tremors to extremities	☐ Agitation	☐ Cramping	☐ Tongue tremors
☐ Sweating	☐ Vomiting	☐ Slurred speech	☐ Headache	☐ Diarrhea	☐ Other	

Has patient experienced the following in the past: ***(in regard to chemical use or withdrawal)***

☐ DTs Date:	☐ Profuse sweating	☐ Night sweats	☐ Chest pain	☐ Smothering sensation		☐ Chills
☐ Fear of dying	☐ Shortness of breath	☐ Faintness	☐ Palpitations	☐ Seizures	☐ Fainting	☐ Sleeplessness
☐ Blackouts	☐ Panic	☐ Double vision	☐ Hallucinations	☐ Dizziness	☐ Other	

Diseases associated with chronic use:

☐ Cirrhosis	☐ Pancreatitis	☐ Gastritis	☐ Korsokoff's Syndrome

Patient's Perception

Are you an alcoholic?	☐ Yes	☐ No	☐ Not sure		Are you a drug addict?	☐ Yes	☐ No	☐ Not sure
Have you ever attempted to cut back on drinking/drug use?					☐ Yes	☐ No		
What is your history of abstinence?								
History of participation in 12-Step program and unable to maintain sobriety:					☐ Yes	☐ No		
What are your spiritual beliefs?								
Have you ever felt guilty about your drinking/drug use?				☐ Yes	☐ No	Do you use or drink alone?	☐ Yes	☐ No
Increased tolerance (need more to feel good):				☐ Yes	☐ No			
Decreased tolerance (use a little to get high or intoxicated):				☐ Yes	☐ No			

LEGAL PROBLEMS

☐ Denies any problems				
☐ Automobile accidents: # and nature:				
☐ DUI charges/convictions: # and dates:				
☐ Possession w/intent to sell: # and nature:				
☐ Misdemeanor charges/convictions: # and nature:				
☐ Felony charges/convictions: # and nature:				
Are charges pending?	☐ Yes	☐ No	What charges?	
Are you on probation?	☐ Yes	☐ No	Comments:	
Are you on parole?	☐ Yes	☐ No	Comments:	
Have you ever inflicted self-injury while under the influence?	☐ Yes	☐ No	If yes, explain	
Have you ever harmed anyone else while under the influence?	☐ Yes	☐ No	If yes, explain	

PREVIOUS TREATMENT

Prior CD / Psychiatric Hospitalizations / Treatment

Date	Completed Program Y/N	Type Program / Reason for Admission	Length of Sobriety	Follow-up / Outcome

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Client of Avery L Barber, MEd, LPC acknowledges receipt of the Notice of Privacy Practices (NPP). The Client has read the NPP and understands that Avery L Barber, MEd, LPC may utilize the Client's Protected Health Information (PHI) in the ways described in the NPP. The Client has retained a copy of the NPP.

Client Name: (Printed)_____

Client Signature_____

Date: _____

- ☐ Client refused to sign but was given the NPP.
- ☐ Client's immediate emotional/psychological needs prevented obtaining acknowledgment of NPP.
- ☐ Signed acknowledgment will be requested at the next opportunity to do so.
- ☐ Client unavailable to sign but agreed that copy of NPP could be mailed (Please list full address below).
- ☐ Other (Please specify) or if mailed, list full address:

_____

_____