Revised 9-11-14

VIEWPOINTE COUNSELING
REGISTRATION FORM
PATIENT INFORMATION

Please provide the following information and answer the questions below. Please note all information provided here is protected as confidential information for ViewPointe Counseling purposes only.

Date: _____

Last Name: _____ **First Name:** _____ **Marital Status: S / M /D/Sep/W**

Other Names: _____ **Date of Birth:** __/__/____ **Sex: M F**

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Phone:
Home: _____ **Mobile:**_____ **Other:**_____

Referred By: (How did you hear about us?)

Dr: _____ **Insurance:**_____

Family:_____ **Friend:** _____

Other: _____

Reason for Referral: _____

What significant life changes or stressful events have you experienced recently?

_____
_____
_____
_____
_____

Social History

Family members, relationships & support system:

Name:	**Relationship:**

Are you spiritual or religious? ☐ **Yes** ☐ **No**

Please tell us more about your faith:

Family History of Mental Health

Please answer to the best of your knowledge

In this section please circle yes / no if there is a fmily history of any of the following issues. Then please indicate the family member that had the issue and if they were on your mother / father's side of the family.

Alcohol / substance abuse **Yes / No**

Anxiety **Yes / No**

Depression **Yes / No**

Domestic Violence **Yes / No**

Eating Disorders **Yes / No**

Obesity **Yes / No**

Obsessive Compulsive Behavior **Yes / No**

Schizophrenia **Yes / No**

Suicide Attempts **Yes / No**

Hobbies or Interests:

Employment History and Financial Status

Are you currently employed? **Yes** **No**

Are you happy with your current employment situation? **Yes** **No**

Do you enjoy your work? **Yes** **No**

Is it a stressful Job? **Yes** **No**

Please explain your current work situation:

Other work history:

Are you on disability? **Yes** **No**

Medical History

Rate on a scale from 1 to 5 (one being poor and 5 being excellent) circle ONE

How would you rate your current physical health?

1 2 3 4 5

Please list any specific health problems or conditions you are currently experiencing:

Medical History (cont...)

Primary Care Physician: _____

Are you currently experiencing any chronic pain? ☐ **Yes** ☐ **No**

If yes, please explain:

_____

_____

_____

Please list any medications you are currently taking:

_____

_____

_____

_____

_____

Have you ever been prescribed psychiatric medication? (Please provide dates as well) ☐ **Yes** ☐ **No**

Medication: _____ **Date Prescribed:** _____

_____ _____

_____ _____

Do you have any allergies?

_____

_____

Please let us know what pharmacy you use: _____ **PH#**_____

Location: _____

Please list any specific sleeping problems you are having; including nightmares:

_____

_____

_____

Medical History (cont...)

How would you rate your current sleeping habits?

1 2 3 4 5

How many days a week do you exercise?

_____

At what Intensity do you exercise?

☐ **Low** ☐ **Moderate** ☐ **High**

Have you had any changes in appetite?

Please explain:

_____

_____

_____

Height: _____ **Weight:** _____

Substance Abuse

Do you have a history of, or currently use, drugs or alcohol? ☐ **Yes** ☐ **No**

If so, please explain:

_____

_____

_____

Have you received treatment for drugs or alcohol? ☐ **Yes** ☐ **No**

Where / When:

_____

_____

_____

Substance Abuse (cont...)

Do you smoke or use nicotine products? ☐ **Yes** ☐ **No**

What do you use and how much:

Emotional Health

Are you currently experiencing overwhelming sadness, grief, or depression? ☐ **Yes** ☐ **No**

If yes, how long have you had these feelings and what are your symptoms?

Are you currently experiencing anxiety, panic attacks, or have any phobias and what are your symptoms? ☐ **Yes** ☐ **No**

If yes, when did these begin?

Education

What is your educational history?

_____

_____

_____

Legal History

Have you ever been arrested? ☐ **Yes** ☐ **No**

Dates of arrest: _____ **Charges:** _____

_____ _____

_____ _____

Sentence: _____

Has CPS ever been involved? ☐ **Yes** ☐ **No**

If yes, please explain:

_____

_____

_____

_____

_____

Previous Counseling or Mental Health History

Have you previously received any type of mental health services? (Psychotherapy, psychiatric services, inpatient treatment, etc.)

☐ **No**

☐ **If yes, please give us the name and location of former therapist / practitioner, and dates of treatment:**

Name & Location; Dates:

_____

_____

_____

_____

What are your strengths?

_____

_____

_____

_____

_____

What are your weaknesses?

_____

_____

_____

_____

What would you like to accomplish with your therapy?

_____

_____

_____

_____

_____

_____

_____

_____

In case of an emergency who should we contact?

Name:_____ **Phone:** _____

_____ _____

Please make sure the following pages are signed and dated before returning this packet to the front desk.

If there is any additional information you wish to share please use the space below:

_____

_____

_____

_____

_____

Rev 3-24-15 WL

WELCOME TO VIEWPOINTE COUNSELING

Welcome to ViewPointe Counseling & Psychiatric Center. **Please fill out the following pages to the best of your ability. Make sure they are signed and dated.**

The first set of pages contains our policies and consent forms for your treatment. The rest of the packet will aid the counselor and doctor in your treatment.

When you are finished bring the packet up to the front window.

Additionally, please list an emergency contact below.

Name: _____ **Phone:** _____

Relationship:_____

If there is any additional information you wish to share please use the space below:

_____

_____

_____

_____

_____

APPOINTMENT COMPLIANCE POLICY

For Therapist / Psychiatrist

TO EXISTING AND NEW CLIENTS:

Our Mission:

We are primarily a counseling based agency. All new patients are set up with a counselor who will establish a treatment plan for you. This treatment plan may or may not include an appointment to see the doctor. It is ultimately up to the counselor when (if) you are scheduled with the doctor.

Counseling Appointment Compliance:

We understand there will be times that appointments can't be kept. However, it is vital to the success of your treatment that you stay compliant with the treatment plan your counselor has set forth for you. This includes providing a 24-hour notice in the event that you can't keep your appointment.

Non-Compliance

We reserve the right to cancel any upcoming appointments you have if you are not compliant with your treatment plan with your counselor / doctor. This may ultimately result in the termination of our services.

Please work diligently to see that you follow your treatment plan.

Your signature below indicates you have received, read, and agree to the terms of this policy.

_____ _____

Signature of Client /Parent/Guardian Date

VIEWPOINTE COUNSELING
NO-SHOW AND CANCELLATION POLICY CONTRACT
For Therapists/Psychiatrists

TO EXISTING AND NEW CLIENTS:
In order to create more availability for those clients who show dedication to their treatment and for those clients waiting to receive services, it is necessary for our agencies to work towards a zero tolerance policy for no-show/no-call clients and for those who frequently cancel their appointments. Therefore:

Effective March 25, 2013 the fee for missing an appointment (without a 24-hour notice) will be:

- $25.00 for therapy appointments
- $50.00 for appointments with the Psychiatrist.

Please keep in mind that this fee will not be covered or paid by your insurance. You will be billed and will be expected to pay the fee in full before your next appointment can be scheduled. In addition, your services will be terminated following 2 occurrences of missing an appointment without providing a 24-hour notice.

CANCELLATIONS:

YOU MUST CALL 24 HRS IN ADVANCE

- You must call during normal business hours to cancel and reschedule an appointment.
- Please do not leave a voicemail message to cancel your appointment this will not be considered a twenty-four hour notice.
- Please identify the reason for your cancellation.
- Please work with the secretary to reschedule for the same week if possible.

FAILURE TO CALL 24 HOURS IN ADVANCE:
If you do not give 24 hours' notice for your cancellation:

- You will be charged a $25.00 fee for therapy/ $50.00 fee for Psychiatrist.
- Due to the amount of people who are currently on our wait list it could be a month before we are able to get you in to see the counselor or psychiatrist.
- In the event your case is closed due to cancellations, your file may include a statement addressing non-compliance for the treatment process.

Please work diligently to see that you follow treatment protocol.
Your signature below indicates you have received, read, and agree to the terms of this policy.

_____ _____
Signature of Client/Parent/Guardian Date

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

- You must pay any co-payment and applicable deductible amounts at the time of service.
- If you are not insured, or if the services being provided are not covered by your insurance, you will be expected to provide payment in full for our services at the time they are rendered.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- In those instances where we have a participating provider agreement with your insurance company for an agreed upon negotiated rate for our services, an adjustment will be made in the amount of the difference between this rate and our normal fees at the time we receive payment from your insurance company. You will remain responsible for required co-payments, applicable deductible amounts and any services that are not covered by your insurance plan.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- Your health plan may refuse payment of a claim for some of the following reasons:

    1. You have not met your full calendar year deductible
    2. The type of service required is not covered by your plan
    3. The health plan was not in effect at the time of service
    4. You have other insurance which must be filed first
    5. We are not in your insurance company's network

- Please understand that just because we accept the type of insurance you may have does not guarantee coverage of services. We may not be in their network. Financial responsibility for services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limiations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as patient to pay the denied amounts in full.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier.

_____ _____

Signature of Patient Patient Name—Printed

_____

Date

Consent to Use Protected Health Information for Treatment, Payment, and Health Care Operations (TPO)

I consent to allow Debra Corn N.P. Inc./Best Way Counseling Inc. to use or disclose my protected health information for treatment, payment, and health care operations.

- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.
- Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.
- Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting; premium rating, and other activities related to health insurance contracts; medical reviews; legal reviews; auditing functions; and business management and general administrative activities of Debra Corn N.P. Inc./Best Way Counseling Inc.

I consent to allow Debra Corn N.P. Inc./Best Way Counseling Inc. to disclose my protected health information for treatment activities of another provider.

I consent to allow Debra Corn N.P. Inc./Best Way Counseling Inc. to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Debra Corn N.P. Inc./Best Way Counseling Inc. to disclose my protected health care information to another covered entity for health care operations activities, provided that Debra Corn N.P. Inc./Best Way Counseling Inc., and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations, or for the purpose of health care fraud and abuse detection or compliance.

I grant Debra Corn N.P. Inc./Best Way Counseling Inc., or agents working on their behalf, permission to contact my insurance company (-ies) for my benefits and to provide the necessary information for payment of my claim. I also authorize and request my insurance company to pay directly to Debra Corn N.P. Inc./Best Way Counseling Inc. the amount due in my pending claim for psychotherapeutic treatment and services, by reason of such treatment and services rendered.

_____

Insurance Company Name and Address
Consent to Use protected Health Care Information for TPO

Name of patient _____
(Please print)

Signature of Person
Authorizing Consent _____ Witness Signature: _____

Date of Signature: _____

Consent for Evaluation and Treatment

The undersigned hereby requests and agrees to an evaluation of_____ by Best Way Counseling, Inc. and/or Debra Corn N.P. Inc. staff. This is a voluntary assessment /evaluation and further care and/or treatment may be recommended.

I agree not to hold Best Way Counseling, Inc. also D.B.A. ViewPointe Counseling responsible for any adverse effects as a result of such evaluation and/or referral for services. Best Way Counseling, Inc. also D.B.A. ViewPointe Counseling will maintain patient confidentiality in accordance with state and federal regulations. I authorize Best Way Counseling, Inc. also D.B.A. ViewPointe Counseling to release any/all diagnostic information from this evaluation and subsequent treatment to other professional staff at this facility in order to facilitate care. Having been apprised of the recommendations made from this evaluation, I voluntarily consent to services by Best Way Counseling, Inc. also D.B.A. ViewPointe Counseling with the following conditions:

- To maintain the confidentiality and to respect the right's of privacy of other clients.
- To participate in treatment services and understand that I will be kept informed of plans for treatment and may withdraw this consent at any time.

This information may not be disclosed or used for any other purposes than as stated in The Consent to Use Protected Health Care Information for Treatment, Payment, and Health Care Operations and the Privacy Practices of Best Way Counseling, Inc. also D.B.A. ViewPointe Counseling I understand Best Way Counseling, Inc. also D.B.A. ViewPointe Counseling is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to provide me with a copy of Privacy Practices of Best Way Counseling, Inc. also D.B.A. ViewPointe Counseling which I am entitled, but not required, to review prior to consenting to treatment and consenting to the use of protected health care information for treatment, payment and health care operations.

_____ _____
Patient Signature **Date**

_____ _____
Parent/Guardian's Signature (if applicable) **Date**

_____ _____
Witness Signature **Date**

Verbal consent may be accepted only in the event written consent cannot be obtained, but shall be accepted only if verbal consent is witnessed and signed by two persons. Verbal consent for the above was obtained on _____, and given after full disclosure of this form to _____ **Date**
Parent/Guardian

Consent was witnessed by:

_____ _____
Witness **Witness**

Best Way Counseling, Inc.
also D.B.A.
ViewPointe Counseling SM
Acknowledgment Form

I, _____, acknowledge that I have received a copy of **Notice of Privacy Practices of Best Way Counseling Inc. *also* D.B.A. ViewPointe Counseling SM** effective April 14, 2003, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____
Patient Signature Date

_____ _____
POA/Guardian Signature Date

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors / Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications

_____ _____

Client Signature (Client's Parent/Guardian if under 18) TODAY'S DATE