PLEASE HAVE A SEAT IN THE WAITING ROOM AND COMPLETE:

Initial appointment with:
KEVIN MOORE

PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name _____ Last Name _____ MI ____

Birth date _____ Age _____ Male ____ Female ____

Street _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

INSURED / PRESPONSIBLE PARTY INFORMATION

Relationship to patient: _____self _____spouse _____parent _____guardian _____other

Name _____ Male_____ Female _____

Address _____ City _____ State _____ Zip _____

Birth date _____ Phone _____

Employer's Name _____ Work Phone _____

Employer's Street _____ City _____ State _____ Zip _____

INSURANCE INFORMATION (if approved/using)

Primary Insurance:
Policy holder name (if different from patient): _____

Address _____ City _____ State _____ Zip _____

Birth date _____ Phone _____

Policy # _____ Group # _____ ID # _____

Insurance Company _____ Phone _____

Address _____ City _____ State ____ Zip _____

Did you contact your insurance co. before coming today? _____ Authorization # _____

Secondary Insurance:
Policy holder name (if different from patient) _____
Address _____ City _____ State _____ Zip _____
Birth date _____ Social Security # _____ Phone _____
Policy # _____ Group # _____ ID # _____
Insurance Company _____ Phone _____
Address _____ City _____ State _____ Zip _____

If Kevin Moore is submitting payment of services to your insurance company, read and sign below:
I authorize payment of these services to the provider above and I understand that any outstanding balance is my financial responsibility
This assignment will remain effective until revoked in writing. A photocopy or fax of this assignment is to be considered valid as the original.

Signed _____ Date_____

CONSENT TO TREATMENT

I acknowledge that I have received the Welcome Statement. I do hereby seek and consent to take part in the treatment by the therapist named below.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I know that I must call to cancel an appointment at least 24 hours before the time of my appointment. If I do not cancel or do not show up, I will be charged for that appointment.

I am aware that an agent for my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

Agreement to Pay

I, the client (or person acting for the client), request that Kevin Moore, LPC, provide counselling services to me or to _____ who is my _____ and I agree to pay the fee of $170.00 for the first visit and $145.00 per 45 minute sessions that follow.

I agree that I am responsible for the charges for services provided to me (or this client). Also, if I am using my insurance then the company may make payments on my (or this client's) account. I am still responsible for what my insurance does not cover.

If using insurance, I hereby assign medical benefits to be paid to the therapist above. A photocopy of this assignment is to be considered as good as the original.

My signature below shows that I understand and agree to these statements.

_____	_____	_____
Signature of client (or person acting for client)	Printed name	Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	_____
Signature of therapist	Date_____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited.

PROVIDER-PATIENT SERVICES AGREEMENT

This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. When you sign this document, it will also represent an agreement between us.

Mental Health Services

There are many different methods I may use to deal with the problems that you hope to address ranging from assessment to treatment. This process calls for a very active effort on your part. Since treatment and assessment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, treatment and assessment has also been shown to have many benefits. But there are no guarantees of what you will experience.

Appointments and Cancellations

It is not my policy to "double book" appointments, so the time is exclusively committed to your appointment. When an appointment is missed, my schedule is seriously disrupted as I am unable to make this time available to other clients. For this reason 24 hours notice is required of your intent to cancel an appointment. If you cancel an appointment without 24 hours notice, or if you miss an appointment, you will be charged the full amount of the session. These charges are not covered by insurance, it is the patient's responsibility, and is due before the next scheduled appointment.

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. While I keep regular daytime office hours, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail, or by the secretary. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are having an emergency and the emergency cannot wait for a return phone call, dial 911 or go to the nearest emergency room. If I will be unavailable for an extended time, there will be an on-call therapist covering in cases of emergencies.

Limits on Confidentiality

The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities. However,

-If a patient threatens to harm himself/herself or others I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. For this a release is not required.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon them, other than by accidental means, or has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

- If I determine that a patient presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and or contacting the police, and or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. Your Psychotherapy Notes cannot be sent to anyone else, including insurance companies without your written, signed Authorization.

Parents Rights

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Minors & Parents

For patients under 18 years of age privacy in psychotherapy is often crucial to successful progress, particularly with teenagers. I will provide the parent with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. If at any point during treatment I feel that the child is in danger or is a danger to someone else, I will notify the parents of my concern.

Insurance Reimbursement and Confidentiality

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by contract with your insurance company directly.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship

_____ _____

Signature: Date: