Responsive Centers for Psychology and Learning

7501 College Boulevard, Suite 250 ◆ Overland Park, Kansas 66210
Telephone: (913) 451-8550 ◆ Fax: (913) 469-5266

Appointment Date/Time:

Client Registration Form — Adult

Today's Date: **Name of Therapist/Clinician:** **Referred by:**

CLIENT INFORMATION

Client's Last Name: First Name: MI: Birth Date: Age: Sex:

Street Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone: Social Security #:

Marital Status: Single Mar Div Sep Wid Name of Spouse/Significant Other:

Employer: Occupation: Student: Full time Part time N/A

School:

FINANCIALLY RESPONSIBLE PARTY (if different from above)

Last Name: First Name: MI: Birth Date: Social Security #:

Street Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone: Employer:

EMERGENCY INFORMATION

Last Name: First Name: Relationship to Client:

Home Phone: Cell Phone: Work Phone:

CLIENT'S RIGHTS AND RESPONSIBILITIES

Clients have the right to:

— Be treated with professionalism and respect
— Confidentiality (see Notice of Privacy Rights)
— Receive explanations about office procedures, or answers to any questions you may have
— Participate in decisions regarding your treatment plan
— Consent to or refuse any treatment

Clients have the responsibility to:

— Provide information needed by the professional staff to care for you
— Keep all scheduled appointments and be on time
— Cancel at least 24 hours in advance if you are unable to keep an appointment
— Pay your fees, deductibles, coinsurance and copays
— Provide insurance information if you wish to use your insurance benefits
— Obtain any authorizations required by your insurance company prior to your initial visit

Responsive Centers for Psychology and Learning

Name of Client: **Name of Therapist/Clinician:**

FINANCIAL POLICY

Copays for clients covered by insurance are due at the time services are rendered. For clients who are not using insurance, or are using an insurance plan with which their clinician is not contracted, payment in full is due at the time of service. Upon request, we will provide you with a Visit Summary to file with your insurance company for reimbursement.

If your insurance company requires prior authorization and you have not obtained it, the cost of that visit will be your responsibility. It is your responsibility to contact your insurance company to determine your outpatient mental health benefits. If your insurance changes during your treatment, it is your responsibility to provide that information to our office, along with any authorizations required by your new plan.

I have read and understand the above stated policies.

_____ _____
Initials Date

AUTHORIZATION OF PAYMENT

Please choose **ONE** of the following:

1. **I am a private pay client.** I will be responsible for payment in full at the time each service is rendered.

   _____ _____
   Initials Date

2. **I authorize payment of insurance benefits to Responsive Centers for Psychology and Learning**, 7501 College Blvd, Ste 250, Overland Park, KS 66210 for services rendered. I further authorize the release to my insurance company of any medical or other information necessary to process my insurance claims. I understand that I am responsible for all balances not paid by my insurance company, including, but not limited to, deductibles, coinsurance, and copays.

   _____ _____
   Initials Date

EAP (EMPLOYEE ASSISTANCE PROGRAM) POLICY

I understand that if I am entitled to benefits through an Employee Assistance Program, I must present the billing information and the authorization number for that benefit **at my first appointment**. If, during the course of my treatment, I find out that I was entitled to an EAP benefit that I was unaware of, Responsive Centers will begin billing my EAP with the **next session**, provided I have obtained an authorization, and regardless of the beginning date of that authorization.

_____ _____
Initials Date

NO SHOW/LATE CANCELLATION POLICY

I understand that I will be charged for a missed appointment, or if I cancel an appointment less than 24 hours in advance. These fees must be paid at the time of the next appointment. **Responsive Centers does not make reminder calls to clients prior to their scheduled appointments**.

_____ _____
Initials Date

I have read and understand all of the above policies.

_____ _____ _____
Printed Name Signature Date

Responsive Centers for Psychology and Learning

Name of Client:	**Name of Therapist/Clinician:**

PRIMARY INSURANCE INFORMATION

Primary Policyholder is: Self Spouse Other

Please complete the following if the primary policyholder is someone other than yourself:

Primary Policyholder's Last Name: First Name: MI: Birth Date: Social Security #:

Street Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone: Relationship to Client:

Please complete the following <u>only</u> if you are unable to supply a copy of your card:

Primary Insurance Company Name: ID#: Group #: Phone #:

Street Address: City: State: Zip:

SECONDARY INSURANCE INFORMATION (if applicable)

Secondary Policyholder is: Self Spouse Other

Please complete the following if the secondary policyholder is someone other than yourself:

Secondary Policyholder's Last Name: First Name: MI: Birth Date: Social Security #:

Street Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone: Relationship to Client:

Please complete the following only if you are unable to supply a copy of your card:

Secondary Insurance Company Name: ID#: Group #: Phone #:

Street Address: City: State: Zip:

Responsive Centers for Psychology and Learning

CONSENT FOR TREATMENT — ADULT

Welcome to our practice. Please read this document carefully and note any questions you might have so you and your clinician can discuss them. ***Once you sign this, it will constitute a binding agreement between us.***

NOTICE OF PRIVACY PRACTICES

By signing this agreement, you consent to the use of your personal health information for purposes of treatment, payment, or health care, according to the **Notice of Privacy Practices** posted on the Responsive Centers' website and provided at the Responsive Centers' office.

PSYCHOTHERAPY

Psychotherapy varies depending on the personality of both the clinician and the client and the particular issues that the client wants to address. There are a number of different approaches that can be used. Outpatient psychotherapy is voluntary and requires an active effort on your part. In order to be most successful, you will have to work both during sessions and at home.

Psychotherapy has both benefits and risks. Psychotherapy often leads to significant reduction of feelings of distress, better relationships, and resolutions to specific problems. Risks sometimes include experiencing uncomfortable levels of feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Psychotherapy sometimes requires recalling unpleasant aspects of your history. It is important that you discuss these issues in an honest and forthright manner. There are no guarantees about results.

By the end of the first few sessions, your clinician will be able to offer you some initial impressions of what your work will include and an initial treatment plan. You should evaluate this information along with your own assessment about whether you feel comfortable continuing. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the clinician you select.

SESSIONS

If psychotherapy is initiated, 45-50 minute meetings will be scheduled at mutually agreed upon times. ***Once an appointment is scheduled, you will be expected to pay for it unless you provide 24-hours advance notice of cancellation (unless you and your clinician agree you were unable to attend due to circumstances beyond your control).*** Missed appointments are not insurance reimbursable and must be paid for by the client.

Your clinician will be happy to discuss session fees with you. You are expected to pay all copays at the time of each session. In addition to your appointments, we charge on a prorated basis for other professional services that are not insurance reimbursable, such as report writing, telephone conversations that last longer than 10 minutes, attendance at meetings, or consultations with other professionals that you have authorized or requested, preparation of records or treatment summaries, and/or the time required to perform any other services which you may request of your clinician.

CONFIDENTIALITY

In general, the confidentiality of all communications between you and your clinician is protected by law. Clinicians can release information only with written permission, with some exceptions. In most judicial proceedings, you have the right to prevent your clinician from providing information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require testimony.

There are some situations in which your clinician is legally required to take action to protect others from harm, even though that requires revealing some information about your treatment. If your clinician believes that a child, an elderly person, or a disabled person is being abused, your clinician is required to file a report with the appropriate state agency.

If your clinician believes that you are a serious threat to another person, your clinician is required to take protective actions, which may include notifying the potential victim, notifying the police, and/or seeking appropriate hospitalization. If you threaten to harm yourself, your clinician may be required to seek hospitalization or contact a family member or others who can provide protection.

INDEPENDENT PRACTICE

Responsive Centers for Psychology and Learning is an association of independently practicing professionals who share certain expenses and administrative functions. While clinicians share a name and office space, they are completely independent in providing you with clinical services and are fully responsible for those services. Any matters concerning your clinical care should be addressed with your clinician first. If the matter is not resolved to your satisfaction, you may contact our executive director.

Please note that your clinician is not authorized to practice medicine or prescribe medication, but will work closely with your physician to ascertain any medical or biological origins that may impact your symptoms.

REQUIRED SIGNATURES

I have read the above information and understand its contents. I give my full consent for treatment. I have had the opportunity to read and obtain a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Witness: _____ Date: _____

Responsive Centers for Psychology and Learning

REPORT TO PRIMARY CARE PHYSICIAN

Please choose ONE of the following:

1. **I AUTHORIZE** Responsive Centers to exchange information with my primary care physician: _____

Client's Signature

Please provide the following information so that we are able to contact your physician. A phone book is available in the waiting room for your convenience.

Client's Name:	Client's Date of Birth:
Client's Social Security #:	Authorization # (if applicable):
Physician's Name:	Physician's Phone #:
Physician's Address:	Physician's Fax #:

2. **I DO NOT** authorize Responsive Centers to exchange information with my primary care physician: _____

FOR OFFICE USE ONLY

This is a(n): Initial Summary Interim Summary Termination Summary

Suggested Diagnoses:

Axis I: _____

Axis II: _____

Psychotropic Medications:

Current psychotropic medications: _____

Please evaluate this client for the appropriateness of medication for the treatment of: _____

Treatment Goals:

_____

_____

Treatment Modalities: Individual Therapy Family Therapy Group Therapy Couples Therapy

Psychotropic medication Referral to community resources: _____

Psychologist/Clinician Signature: _____ Date: _____

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Please complete and return if medication is prescribed or changed or if there are any medical conditions or medications that may be causing or contributing to the client's symptoms of mental disorder.

Medication prescribed: _____ Dose: _____

Medication prescribed: _____ Dose: _____

Physician's Signature: _____ Date: _____

Responsive Centers for Psychology and Learning

BIOGRAPHICAL INFORMATION
This information is to help your therapist/clinician prepare for your visit and to facilitate planning for your treatment.
Your Name: **Nickname:** **Date of Birth:** **Age:**
PRESENTING PROBLEMS
What concerns or problems, including symptoms, convinced you to seek help now?
These problems are: Mildly upsetting Moderately severe Very severe Totally incapacitating
How long has it been a problem? Have you been treated for this problem before?
If yes, who treated you?
FAMILY INFORMATION
Name of Spouse/Significant Other:
Children (Names and Ages):
EDUCATION
Highest Degree Earned: School:
JOB HISTORY
Current Occupation: Years on the Job:
Previous Occupation: Years on the Job:
MEDICAL HISTORY
Primary Care Physician: Date of Last Physical Exam:
Medical problems you are being treated for currently:
Allergies:
Current Medications:

BIOGRAPHICAL INFORMATION (cont'd)
PSYCHIATRIC HISTORY
Previous mental health treatment:
Level of Care: Inpatient Partial Hospital Outpatient
Reason for Treatment:
Treating Clinician(s)' Name(s):
Have you ever attempted suicide? Yes No If yes, when?
Are you currently having suicidal ideation? Yes No Do you have a plan? Yes No
Please describe any family history of psychiatric problems:
ALCOHOL/DRUG USE/ABUSE
Abstain Social Concerned about abuse Recovering
Types of substances:
Frequency: Amount:
Family member(s) abuse? Yes No If yes, whom?
LEGAL HISTORY
Have you ever been arrested? Yes No If yes, for what reason? At what age?
SOCIAL HISTORY
With whom do you discuss difficult problems? Family Friends Others
Do you have a social support group? Yes No
What do you do for pleasure and relaxation?