

NEW PATIENT REGISTRATION

The following questions are designed to help us to better understand your care needs. Please answer as completely as possible. We will be happy to assist you if you have any questions. Parents of minors, please sign all consents.

Date: _____

Patient Name _____ Gender _____

Patient Social Security # _____ Date of Birth _____
(MM/DD/YYYY)

Address _____ Apt. # _____

City, State _____ Zip Code _____

Primary Phone (_____) _____ Secondary Phone (_____) _____
Please Circle: Home or Cell /OK to contact there? Y N Please Circle: Home or Cell /OK to contact there? Y N

Email Address: _____ Other Phone (_____) _____
(See email disclaimer pg. 5)

Race _____ Ethnicity _____ Preferred Language _____

Emergency contact: _____ (_____) _____
Name Relationship Phone Number

Please list others living in your household:

Names	Ages	Names	Ages
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Referred by: _____

Primary Care Physician _____ (_____) _____
Name Phone Number

Primary Insurance Information

Secondary Insurance Information

Insured Name _____

Insured Name _____

Insured SSN _____

Insured SSN _____

Insured Birthdate _____

Insured Birthdate _____

Employer _____

Employer _____

Health Plan _____

Health Plan _____

Phone number (_____) _____

Phone number (_____) _____

Subscriber ID# _____

Subscriber ID# _____

Effective Date: _____

Effective Date: _____

Please inform the front office of insurance changes as soon as possible so staff can verify benefits. If a patient is covered by two insurances, both must be presented to prevent claims being denied. Please note, our office cannot bill medical groups.

Appointment Reminder Text Messages

We send out courtesy **text** reminders 1 business day prior to your appointment. Please indicate below the mobile number on which you would like to receive your appointment reminder information.

Mobile Number (_____) _____ **If you prefer to opt out, please initial here** _____

Please indicate the severity of problems in the following areas of your life:

	No Problems	Mild Problems	Moderate Problems	Significant Problems	Severe Problems	Not Applicable
<u>Depression</u>	1	2	3	4	5	N/A
<u>Anxiety</u>	1	2	3	4	5	N/A
<u>Anger</u>	1	2	3	4	5	N/A
<u>Self-esteem</u>	1	2	3	4	5	N/A
<u>Marriage/Relationship</u>	1	2	3	4	5	N/A
<u>Family</u>	1	2	3	4	5	N/A
<u>Friendships</u>	1	2	3	4	5	N/A
<u>Work or School</u>	1	2	3	4	5	N/A
<u>Money</u>	1	2	3	4	5	N/A
<u>Legal Issues</u>	1	2	3	4	5	N/A
<u>Eating habits</u>	1	2	3	4	5	N/A
<u>Sleep</u>	1	2	3	4	5	N/A
<u>Substance Abuse</u>	1	2	3	4	5	N/A
<u>Concentration</u>	1	2	3	4	5	N/A
<u>Behavior</u>	1	2	3	4	5	N/A

What do you view as your strengths at this point in your life?

Please use the space below to provide any other information you feel might be important:

Please describe your reason for seeking treatment at this time:

Please describe any significant current stressors or issues in your background or history which may be related to the current problem:

Have you received mental health treatment before? _____ Yes _____ No If yes, please describe:

Do you have any medical problems? _____ Yes _____ No If yes, please describe:

Are you currently taking any medications? _____ Yes _____ No If yes, please list names and dosages:

Do you use tobacco? _____ Yes _____ No

If yes, how much? _____ How often _____ Last taken _____

Do you consume alcohol? _____ Yes _____ No

If yes, how much? _____ How often _____ Last taken _____

Please list any drugs you have experimented with:

Drug	Amount	Frequency	Last taken
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Treatment Philosophy-Explanation of Brief Therapy

Brief therapy is goal-directed, problem-focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a timely manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask.

Initial here: _____

Limits of Confidentiality Statement

All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patient presents as a physical danger to self (Johnson vs. County of Los Angeles, 1983).
4. The patient presents as a danger to others (Tarasoff vs. Regents of University of California, 1967).
5. Elder abuse and /or neglect are suspected (Welfare & Institution and/or Penal Codes).
6. Child abuse and/or neglect are suspected or a person who knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or exchanges a film, photograph or video in which a child is engaged in an act of obscene sexual conduct (Melendez Chapter 264, Statutes of 2015)

All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency.

Initial here: _____

HIPAA Compliance

Our practice complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review the Notice of Privacy Practices posted in the waiting room. You may request a copy of this notice and of your treatment records if you wish.

_____ I have had an opportunity to review the Notice of Privacy Practices.

In addition: I authorize the release of information pertaining to claims, certification, case management, quality improvement, benefit administration and other related purposes to my health plan. I authorize the release of information to Foothills Psychological Services' treatment professionals for purposes of coordination of treatment and peer review.

_____ I authorize the release of information to my Primary Care Physician.

_____ I do not authorize release of information to my Primary Care Physician.

Initial here: _____

Patient Name: _____

Foothills Psychological Services, Inc-CONSENT FORM Page 2of 3

E-Mail Disclaimer: Please note that if the patient/legal guardian provides our practice with an e-mail address, the patient/legal guardian is providing ***Foothills Psychological Services, Inc. (FPS)*** with automatic authorization to communicate medical (and account) information to the patient/legal guardian and/or any of their elected representatives, via that e-mail address. Additionally, this authorization allows our practice to e-mail medical information to any healthcare provider directly involved in the care of the patient (and who elects to communicate via e-mail). If the patient/legal guardian elects not to have any information communicated via e-mail, the patient/legal guardian is hereby instructed to not provide our office with an e-mail address and to provide our office with written notification prohibiting the sharing of the patient’s information electronically with any entity.

Initial here: _____

Emergency Access

Practitioners are available after hours to handle emergencies. Your provider will discuss after-hours procedures with you. For life threatening emergencies, you should dial 911 or go to the nearest emergency room.

Initial here: _____

Financial Terms- Insurance Coverage and Co-payments

You are responsible for obtaining prior authorization for treatment from your insurance Carrier. We will bill your insurance; however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Missed appointments & Late Cancellations are not covered by your insurance and the charges associated with them are your responsibility.

Co-payment amounts are set by your benefits plan and are expected to be paid at the time of service.

We will make every effort to inform you of costs when you are beyond or outside your benefits. For special modalities of treatment not covered by your benefits plan, a written agreement needs to be signed between you and Foothills Psychological Services, Inc. This agreement will outline your understanding that the services are not covered and the fees and the treatment plan you may expect.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

I will notify the practitioner before services are rendered if there are any changes in insurance carrier and/or coverage. If I become ineligible for insurance coverage, I will notify the practitioner and understand I will become responsible for 100% of the bill.

Initial here: _____

Cancellation and Missed Appointment Policy

Scheduled appointment times are *reserved especially for you*. We make every effort possible, as a courtesy, to give you an appointment reminder via an automated appointment reminder system but if an appointment is ***missed*** or ***not canceled by noon the business day prior to the appointment***, you will be charged according to our scheduled/posted fee and instructions of your benefit plan. Please speak with the receptionist for current fees. Repeated “no show” appointments could result in referring you back to the insurance company for reassignment to another practitioner. Your insurance company *will not be billed* for fees associated with missed or canceled appointments. Rescheduling or cancelling on the part of the provider does not transfer to a monetary amount, therefore provider cancellation is not included in this clause.

Initial here: _____

Patient Name: _____

Appeals and Grievances

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient care is not certified. I understand that I would request an Appeal directly through my insurance company and that I risk nothing in exercising this right.

I also understand that I may submit a Grievance to my Practitioner at any time to register a complaint about my care or I may send the complaint directly to my insurance company.

I understand that the California Department of Managed Health Care (DMHC) is responsible for regulating health care services. The California DMHC has a toll-free telephone number (800-400-0815) to receive complaints regarding health care plans. If I have a grievance involving an emergency appeal or with an appeal that has not been satisfactorily resolved by the plan, I can call the DMHC's toll free telephone number.

Initial here: _____

Patient Name (Please Print)

Date

Consent for Coordination with Insurance company

I hereby authorize the release of information to my insurance company as necessary to obtain authorization and payment of medical benefits to the physician/therapist for services rendered. I also authorize use of a photocopy of my signature to file insurance claims. I further authorize my insurance company to issue payment to Foothills Psychological Services for services rendered.

Initial here: _____

Patient Name (Please Print)

Date

Consent for Treatment

I authorize and request my practitioner to carry out psychological and / or psychiatric exams, treatment and / or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

Initial here: _____

Patient Signature

Date

Patient Name: _____

General Consent for Child or Dependent Treatment

I/We, _____

Print Name(s) of Legal Guardian(s)

being the legal guardian(s) or legal representative(s) of the patient and on the patient's behalf legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that *all policies and obligations* described in this statement apply to the patient I/we represent. I/we agree to assume full financial responsibility for *all* charges not covered by insurance.

Signature of Legal Guardian/Legal Representative

Relationship to Patient

Signature of Legal Guardian/Legal Representative

Relationship to Patient

HEALTH CARE COORDINATION FORM

Dear _____,

I wish to inform you that the patient identified below has been seen at Foothills Psychological Services, Inc. ***We are not requesting information from you at this*** time but would like to have this release of information in your records so that your treatment efforts can be coordinated as necessary. Please contact us in our Chino office at (909) 902-9111 or in Upland at (909) 946-4222 if additional information is needed.

Sincerely,

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name

Date of Birth

I hereby authorize the release of all medical, chemical dependency and mental health information necessary to coordinate the treatment I am receiving from the following providers:

Primary Care Physician

Address

Psychiatrist

Address

Psychologist or Psychotherapist

Address

I understand authorizing the disclosure of information between my treatment providers is voluntary. This authorization becomes effective on the date signed and may be revoked by me at any time. If not earlier revoked, this authorization shall terminate automatically one year from today's date. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the information authorized by this release will be provided to the authorized recipients only and that these recipients are prohibited from further disclosure without my specific written consent. The information to be released may include my medical and psychiatric history, current condition, test results, diagnosis, medication and treatment plan. I further understand that I have a right to receive a copy of this authorization upon my request.

Signature of Patient or Legal Guardian

Date

Foothills Psychological Services, Inc

Cancellation / No Show Office Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you must provide more than one business day. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

With cancellations made less than one business day we are unable to offer that slot to other people. Office appointments which are canceled with less than one business day notification will be subject to a **\$60.00 cancellation fee**.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW and will be subject to a **\$60.00 no show fee**. Repeated “no show” appointments could result in referring you back to the insurance company for reassignment to another practitioner.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full or payment arrangements must be made with the billing office before the patient’s next appointment.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

Patient Name

Patient Signature

Date

Name of legal Guardian/Representative

Signature of Legal Guardian/Representative

Date