CHEROKEE COUNSELING & PSYCHOLOGICAL ASSOCIATES, L.L.P.

NEW CLIENT REGISTRATION

Welcome to our practice. Please read and complete all 6 pages of the following information. Thank you.

Today's Date_____

How did you hear about Cherokee Counseling?

ı Sign ı Web Site ı Insurance company ı Family or Friend ı Yellow Pages ı Other

ı Doctor - _____ May we thank them? Yes ı No ı
(Doctor name or agency)

Patient's name _____ **Date of Birth** _____ Age _____
(Last) (First) (M)
Address _____City_____ Zip_____
Phone number(s) Home (____) _____ Work (____) _____ can we call you there Yes/No
Cell \ Pager (____) _____ Gender: Male/Female Drivers License Number _____
Marital Status: Married/Single/Sep/Widow/Divorce, How Long? _____ Student: Full/Part/NA
Grade _____ School_____
Social Security Number _____ Employed: Full time/Part Time/Not Applicable
Employer's name_____
Work Address_____ City _____ State ____ Zip _____

If Patient Is a Child or Minor, We Need the Following Information

Mother's Name/or Guardian _____
Address (if different from patient's) _____
City _____ State _____ Zip_____
Phone Numbers: Work _____Cell _____ Home _____
Social Security Number _____ Employed: Full Time/Part Time/ NA
Employer's name and address_____
_____

Father's Name/or Guardian_____
Address (ifdifferent from patient's)
_____
City _____ State _____ Zip_____
Phone Numbers: Work _____Cell _____ Home _____
Social Security Number _____ Employed: Full Time/Part Time/ NA
Employer's name and address _____
_____
If Parents live at separate addresses, which address do we use for statements? Mother / Father
Who is the custodial parent for child? Mother / Father or Joint
** Please note that both parents will be held responsible for account balances. If there is a co-payment or fee due at the time of service, the parent bringing the child to the visit will need to make the payment.

Insurance Information

Name of insured person _____ Relationship to patient: Self/Spouse/Parent/Other
Address of insured person: Same as patient's mother/father
Insured's social security number_____ **Date of Birth** _____ Gender: M/F
Name of employer (or group) insurance is supplied through
_____
Address _____ City _____ State _____ Zip_____
ID# _____ Group/Plan #_____
Phone number to verify benefits_____
** We must make a copy of all insurance cards before we will accept assignment.

Medical Information

Patient's Physician _____ Phone #_____
Physician's Address _____ City _____ State _____ Zip _____
List any current medical or health problems: _____
_____
List any medications that you are currently taking or have taken in the past six (6) months. Also please indicate for which conditions you are taking the medications and the name of the physician who prescribed the medications:
_____
_____

Personal Information

Patient's highest grade completed: _____ Degrees: _____

List any other person(s) residing in household:

Name	Age	Relationship to patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Nearest Relative not living in home (in case of emergency)
Name: _____ Relation: _____ Home Phone _____
Address: _____ City _____ State _____ Zip_____

Brief History

What are the main reasons you are seeking treatment today? (Use reverse side if necessary) _____
_____
_____
_____

Do you now or have you ever experienced the following to the point where you feel troubled or bothered? (Please Circle)

Aggressiveness/Anger	Drug Abuse	Paranoid Feeling	Sexual Dysfunction
Alcohol Abuse/addictions	Excess Stress	Poor Concentration	Sleep Problems
Anxiety/Nervousness	Hallucinations	Poor Appetite	Strong Fears
Confusion	Homicidal Thoughts	Poor Memory	Suicidal Thoughts
Death of a Loved One	Hopelessness	Racing Thoughts	Low Energy
Depression	Legal Problems	Recent Life-style Change	Weight Issues
Disorientation	Marital Problems	Restlessness	Work Problems
Divorce	Panic Attacks	School Problems	

Has any of your family ever experienced any of the above items to the point that professional attention was sought?
Yes_____ No _____ if yes, please explain: _____
_____
Have you ever received counseling or psychotherapy before? Yes _____ No _____
If yes, where? _____
For what reason? _____
Do you feel like you benefited from this experience? Yes _____ No_____
Name of Counselor/Therapist/Psychiatrist seen previously:
_____

PLEASE READ CAREFULLY AND SIGN THE STATEMENT THAT FOLLOWS

Payment and Insurance Reimbursement Policy

Patients are required to pay all fees in full at the time service is rendered unless other arrangements have been made with your therapist. A completed insurance form can be provided to you so that you may file a claim for direct reimbursement from your insurance company. If you are covered by a managed care company, and authorized for visits, please provide a copy of your insurance card to the secretary. You will also be required to sign the assignment of benefits statement below and **pay your co-payment at each visit**. If you have an unmet deductible, you will be required to pay for the services rendered in full until the deductible has been met. Documentation can be provided for patients wishing to file claims with their secondary insurers.

Insurance policies are quite varied, and it is your responsibility to familiarize yourself with your insurance benefits, including obtaining any pre-authorizations required and verifying coverage. It is important to realize that, regardless of your insurance coverage, it is the patient (or their adult parent/guardian) who is ultimately responsible for payment of services. We will attempt to accommodate your insurance needs. However, if payment is denied, you will be held responsible for the charges you incurred.

Payments are generally accepted in the form of cash, check or major credit cards. Please make all checks payable to your therapist. For any returned checks, the patient will be charged a $20.00 fee. In the event of default of payment, your account may be turned over to a collection agency, which may require disclosure of confidential information. In most collection situations, the only information released is a patient's name, identifying date, nature of services provided and amount due. If your account is delinquent beyond 90 days, you may be assessed a delinquency fee of 30% of the balance.

Assignment of Benefits

I authorize release of any treatment or patient information necessary to process insurance claims. I also authorize payment of insurance benefits to be made to_____
(Enter Therapist's Name)
for services provided at Cherokee Counseling and Psychological Associates.
SIGNED _____ DATE _____
Relationship to patient: Self / Parent / Guardian

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 new federal law that provides new privacy protections and new 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 (Georgia Notice Form) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is available upon request, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Psychological Services
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. This process calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we discussed during therapy sessions at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Appointments and Cancellations
Appointments are generally 45-50 minutes in length. The frequency of your appointments will depend upon your needs. After a suspension of treatment for 30 days or more, your chart will be closed, unless other arrangements have been made. 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**. As these charges are not covered by insurance, it is the patient's responsibility, and is due within one week of the missed 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 unable to reach me and you are having an emergency, you can call our main office number and follow our emergency procedures. You will be called back by me or our on-call therapist. If the emergency cannot wait for a return phone call, dial 911 or go to the nearest emergency room. If I am 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, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Policies and Practices to protect the privacy of your health information).

- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- I also may have contracts with certain Managed Health Care companies. As required by HIPAA, I have a business associate contract with these companies, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

- Any request for the records of a couple must include a signed release from both parties. In group and couples treatment, the record belongs to all parties and confidentiality rules apply to single parts as well as the entire record.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the therapist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

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.

s 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.

b 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 any of the situations arise, 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. You may examine and/or receive a copy of your clinical record with a written request with the following exceptions: in unusual circumstances that involve danger to yourself and others, or makes reference to another person and I believe that access is reasonably likely to cause substantial harm to such other person, or where information has been supplied to me confidentially by others. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of $50 per record. If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request.

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. They also contain particularly sensitive information that you may reveal to me that is not

required to be included in your Clinical Record (and information supplied to me confidentially by others). These Psychotherapy Notes are kept separate from your Clinical Record. They are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Patient Rights
HIPAA provides you with several new or expanded 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, the Georgia Notice form, 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 who are not emancipated, their parents are allowed by law to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. However, because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is often my policy to have an agreement with parents that they consent to not seek access to their child's records. If they agree, during treatment, I will provide them with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. 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.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. 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.

Consent to Treatment

I consent to have _____ provide psychological counseling,
(Enter Practitioner's Name)
psychological or psychiatric evaluation, and/or related mental health treatments for myself or my minor child.

My signature below indicates that I have read and understand the information regarding payment and insurance reimbursement, assignment of benefits, Provider-Patient Services Agreement and consent to treatment. Additionally, the information I have provided regarding my history and condition is true and complete to the best of my knowledge

_____ Date: _____
Client's Signature (or legal guardian if client is a minor)