

# PSYCHOLOGY CENTER

*of*

## IDAHO FALLS

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### Registration Form

Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Mailing Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: Home \_\_\_\_\_ Work/Cell \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Current Concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employer/School Information:  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_

Highest Grade Completed: \_\_\_\_\_  
Current School (if a student): \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Will a copy of this report need to be sent to any other health care provider of school? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you request insurance submission? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes:  
Insurance Provider: \_\_\_\_\_

Policy #: \_\_\_\_\_ Copy of card taken? \_\_\_\_\_

# INFORMED CONSENT FOR TREATMENT

This form will provide information about our services and about your rights and responsibilities as a client. Please be sure to discuss any questions with your psychologist (Dr. Aaron Harris or Dr. Carol Anderson). Your signature at the bottom indicates that you understand the information and freely consent to participate in treatment.

I understand that treatment may involve discussing relationship, psychological, and/or emotional issues that may at times be distressing. I also understand that this process is intended to help me personally and/or with my relationships. I am aware of alternative treatment options and other treatment providers available. All of my questions about treatment options have been answered satisfactorily. If I have further questions, I understand that Dr. Harris or Dr. Anderson will either answer them or find answers for me. I understand that I may leave therapy at any time, although I understand that this is best accomplished in consultation with my therapist. I also understand that my therapist reserves the right to discontinue treatment, if clinical judgment calls for such action (e.g. based on client status/progress, changes in client needs, provider practice issues, etc).

## CONFIDENTIALITY:

The information obtained in this evaluation is confidential and will not be released to any person or organization without your written permission. The only exceptions to this policy are rare situations in which we are required by law to release information without your permission. These are 1) if there is evidence of physical and/or sexual abuse of children, or abuse to the elderly; 2) if we judge that you are in danger of harming yourself or another individual; and 3) if your records are subpoenaed by the court. In the rare event of any of these situations, we would attempt to discuss our intentions with you before an action is taken, and would limit disclosure of confidential information to the minimum necessary to ensure safety.

## FEE AND PAYMENT POLICY:

The standard fee for counseling is \$175 for a 55-60 minute session. The standard fee for a 40-50 minute session is \$120. **Payment for co-pays, deductibles, etc. is the client's responsibility, and will be due in full at the time of service.** Submission to private insurance companies may be done, upon request. Pre-authorization, if required, is the responsibility of the client. Any unpaid balance (e.g. due to insurance denial or non-payment) is the client's responsibility.

## AGREEMENT:

I have read the above material, and I fully understand my rights and obligations as a client. I freely agree to treatment, with the specified conditions.

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Name of Client

Date

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Signature  
(Client or parent/legal guardian)

Date

# Acknowledgement of Notice of Privacy Practices: HIPAA

The Notice of Privacy Practices tells you how we may use and share your health records. Please read it.

- We will use and share your health records to treat you and to bill for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of who we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

**I have had the opportunity to receive a copy of the Notice of Privacy Practices.**

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Name of Client

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Signature  
(Client or parent/legal guardian)

Date

## Consent

I give my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Psychology Center of Idaho Falls' Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Psychology Center of Idaho Falls has the right to change privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

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Name of Client

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Signature  
(Client or parent/legal guardian)

Date