Comprehensive
Counseling Services

PATIENT REGISTRATION

Patient Name: _____ (Last) _____ (First) _____ (MI) Nickname: _____

Date of Birth: _____ Gender: Male Female Marital Status: S M W D Social Security #: _____

Address: _____ (Apt#) City: _____ State: _____ Zip: _____

Patient: Home # _____ Cell # _____ Work # _____ Ext: _____

Employment Status: Full-Time Part-Time Student Other Employer's Name: _____

Emergency Contact (Name): _____ Phone #: _____

Relationship to patient: _____

Choose *one* type of appointment reminder you prefer:

☐ Email: Email Address: _____

☐ Text (Requires Cell Phone Number): _____

☐ Phone Call (Requires Phone Number): _____

☐ None (No Reminder)

Billing Information

Responsible Party (who pays the bill?)

Name: _____ (Last) _____ (First) _____ (MI) Phone #: _____

Social Security #: _____ Relationship to patient: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance Company: _____ Ins. Phone # _____

Insurance I.D. # _____ Group #_____ Social Security # _____

Insured Name: _____ Date of Birth_____ Employer: _____

Address: _____ (Apt #) City: _____ State _____ Zip: _____

Insured Phone # _____ Employer: _____

Secondary Insurance Company: _____ Ins. Phone # _____

Insurance I.D. # _____ Group #_____ Social Security # _____

Insured Name: _____ Date of Birth_____ Employer: _____

Address: _____ (Apt #) City: _____ State _____ Zip: _____

Insured Phone # _____ Employer: _____

The above information is correct and I give permission for the office to make appointment reminders as indicated above.

Patient/Guardian Signature _____ ***Date:*** _____

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Consent for Treatment **Pt Name:** **MR #:**

Release of Information & Assignment of Benefits: I have received and read the clinic's Financial Policy and Fee Schedule. I hereby authorize Comprehensive Counseling Services to release to my insurance company and/or associated professionals any information from my medical records that may be necessary to determine benefits payable under my policy. I understand that this information which may be transmitted electronically, may include the diagnosis and treatment of mental illness including alcohol and drug abuse, and developmental disabilities.

Assignment of Benefits: I authorize payment directly to Comprehensive Counseling Services for the benefits otherwise payable to me for the amount that covers but does not exceed services delivered. I guarantee payment of any and all charges incurred for services rendered which are not covered by this assignment or by insurance benefits. **I understand that I may be charged $75.00 for missed appointments as defined in the Financial Policy if not cancelled at least 24 hours prior to the appointment time.** I further understand that all co-payments are due at the time of service and that I am responsible for all balances to be paid within 90 days of the date of service regardless of the status of the insurance claims.

Personal Valuables: I understand that Comprehensive Counseling Services assumes no liability for any loss or damage to personal items or articles.

Patient Rights and Confidentiality: I have read Comprehensive Counseling Service's "Client's Rights and Grievance Procedure" and understand that it is posted in the waiting room. Your treatment is a private and personal relationship between you and your provider. Within our clinic, your provider may review your treatment with a psychiatric consultation team including other behavioral health providers in the clinic. We will only release information about your treatment with your written consent, except in situations that are required by law. By law, we must release information in situations of: (1) abuse or neglect of children; (2) abuse or neglect of the elderly; or (3) cases of probable suicide or homicide. In these cases, your provider may need to take steps to protect people from harm or to warn them such as: (1) contacting a family member; (2) contacting a public agency; or (3) arranging for hospitalization.

Consent for Treatment: I request and authorize Comprehensive Counseling Services, its staff, including psychiatrists, psychologists, and licensed psychotherapists, who may attend to me during this series of outpatient services, to provide and perform such treatment, medication, and other psychological-based interventions which are considered advisable by my treatment provider for my health and well-being. I understand that my treating provider will request my participation in developing my plan for treatment including informing me of the benefits and expected outcomes for treatment, the type of treatment, and alternative options and problems that may arise if I don't receive treatment. I further understand that Comprehensive Counseling Services cannot guarantee the outcome of the treatment provided. I have been informed of the clinic's policy on confidentiality.

I have read and understand the above information. I understand that this consent for treatment is good for no longer than 15 months and may be revoked by me at any time by written notice to the Clinic Director and/or my treating provider. I further understand that I am responsible for any costs incurred prior to the revocation of the consent for treatment and that any information released by my consent prior to revocation of consent for treatment cannot be retrieved. I hereby consent to treatment.

Signature of Patient / Legal Guardian Date

Signature of Witness Date

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Primary Care Physician Coordination

Coordinating your care with your Primary Care Physician offers you the most comprehensive treatment. This is an opportunity for your medical and mental health professionals to discuss how any medical conditions you may have could affect your mental health issues, or how any mental health issues could affect any medical conditions you may be experiencing. Written information we may release to your medical provider may include a diagnostic evaluation identifying mental health or substance abuse problems; progress notes or a summary of your treatment including issues related to medication, mental health and/or substance abuse issues.

While we always encourage coordination of care with your medical doctors, you must first sign a consent to allow us to release this information:

Please check one of the following and sign below:

- ❒ I do not have a primary care physician.
- ❒ I refuse to give permission for my therapist or doctor to either correspond by letter or discuss over the telephone any information about my mental health issues.
- ❒ I give permission for Comprehensive Counseling Services, LLC and my primary care physician or other designated health care provider to exchange information regarding coordination of my medical and mental health issues.

If you are consenting to coordination of care between your therapist or psychiatrist and your medical doctor, please list the contact information for your medical doctor:

Name of Doctor_____

Address_____

City/State_____

Zip Code_____

Phone Number____(_____)_____

Name (print): _____

Signature: _____

Date: _____

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Pt Name: **MR #:**

Acknowledgement of Receipt of Privacy Notice

By signing this form, I, _____, acknowledge that Comprehensive Counseling Services, LLC has provided me with a copy the Privacy Notice that explains how my health information will be handled in various situations. I understand that I am able to discuss any questions I may have regarding the privacy notice with my provider, and I am aware that a Federal law requires that a signed copy of this form be retained in my file.

Signature_____

Date_____