

PATIENT REGISTRATION FORM

Name: _____ Date of Birth: _____ Sex: M F Marital Status:

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work/Cell Phone: _____ Soc. Sec.# _____

Occupation: _____ Employer: _____

Person to receive bills: _____ Resp. Person SS # _____

Referred By: _____ Primary Care Physician _____

Person to contact in case of emergency: _____ Phone: _____

If Patient is a Child:

Mo's Home Phone: _____ Work/Cell Phone: _____ Employer _____

Fa's Home Phone: _____ Work/Cell Phone: _____ Employer _____

Custodial Parent (if applicable) _____ Non-custodial parent _____

Address:(n.c parent) _____ City _____ State _____ Zip _____

Emergency contact person: _____ Phone Number: _____

Family Members/Others Living in Home

Name Relationship to Patient Date of Birth

INSURANCE INFORMATION

Primary:

Name/Type: _____
Subscriber Name _____
Subscriber's Employer: _____

Client ID # _____
Group/Plan # _____
Authorization # _____

Secondary:

Name/Type: _____
Subscriber Name _____
Subscriber's Employer: _____

Client ID # _____
Group/Plan # _____
Authorization # _____

Date of Referral: _____ Date of First Appointment: _____

For Office Use only: Provider Name _____ Dx: _____

Insurance Card Copied (front and back) and attached YES NO Reason _____

LIFE MANAGEMENT ASSOCIATES, INC

Welcome to our office. We would like you to briefly list the issues that brought you to counseling.

1. _____
2. _____
3. _____
4. _____

What specific changes would you like to have been made by the end of counseling?

1. _____
2. _____
3. _____
4. _____

Please indicate if you or any of your biological relatives struggle with any of the following problems:

Problem:	Yes	No	Relation (mo, fa, sis, bro, aunt, cousin, etc.)
Aggression, defiant or oppositional behavior?			
Attentional or impulse control problems?			
Learning Disabilities?			
School Failure?			
Mental Retardation?			
Psychosis or Schizophrenia?			
Manic Depression?			
Depression for more than 2 weeks?			
Anxiety Disorders?			
Tics or Tourette's?			
Alcohol Abuse?			
Substance Abuse?			
Anti-Social Behavior?			
Arrests?			
Physical Abuse?			
Sexual Abuse?			

Are there questions you have for your therapist today?

1. _____
2. _____

Please give this form to your therapist.

CONSENT TO TREATMENT

Client Name _____ Date of Birth _____

Please review the following Life Management Associates (LMA) policies and disclosures before signing and dating the bottom of the form. All clients under the age of 18 must have a parent's or guardian's signed consent before assessment and treatment may begin.

Payment Policies

All copayments are due at the time of service and may be paid by cash or check made out to Life Management Associates. While we make every effort to determine health insurance coverage and gain authorization in advance of treatment, ultimately the client is responsible for payment for services in the event insurance does not pay.

Cancellation Policy

LMA requires at least 24 hours advance notice to cancel an appointment. Monday appointments must be cancelled by the previous Friday. Missed appointments and late cancellations will incur a charge of \$75 which is due before the next scheduled appointment.

Confidentiality

Life Management Associates staff members adhere to strict professional standards of confidentiality which are essential to developing trust. We do not disclose information about your treatment to any other party without written permission from you with the following exceptions:

1. diagnostic code, treatment type, and dates of treatment, or other information needed by insurance companies for payment for services provided;
2. in the case of imminent danger to yourself or another person, or concern about the welfare of a child or vulnerable adult, LMA clinicians are bound by law to try to prevent such harm or alert the relevant authority;
3. if a valid court order is issued for medical records, Life Management Associates staff are bound by law to comply with such requests.

Benefits and Risks of Therapy

While there are significant potential benefits associated with psychotherapy including improved ability to cope with difficult situations and solve problems, better personal relationships, new skills for behavior change, or increased understanding of self and others, it might also pose risks. Risks might include facing uncomfortable feelings; recalling painful memories; or feeling stress associated with change. The process of personal change can be quite varied and individual.

Evaluation of Our Services

LMA is committed to the delivery of quality care in an atmosphere of consideration and respect. LMA clinicians seek to establish a collaborative relationship with clients to develop an individual treatment plan, to set goals and to monitor the progress of treatment. We welcome your comments regarding our services and encourage any suggestions or concerns. These can be addressed directly with your therapist, the Director of LMA Dr. Steven Michelson, or our Practice Manager Gretchen Brommelhoff.

I have read and understand the above and agree to enter into treatment with a Life Management Associates therapist as indicated by my signature below. I understand I may revoke this agreement and end treatment at any time.

Signature

Today's Date

Relationship to Client

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include your initial office visit.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, or obtaining authorization billing, or collection activities and utilization review. An example of this would be sending a claim to your insurance company for payment.
- **Health care operations** include the business aspects of running the practice, such as conducting quality assessment and improvement activities, auditing functions, and cost-management analysis. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

- I authorize LMA to call me at _____ (phone number)
- I authorize LMA to leave messages on the voice mail.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: Gretchen Brommelhoff.

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If you do agree to a restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to reasonable requests to receive confidential communications of protected health information from us by alternate means or at alternative locations.**
- **The right to inspect and, unless deemed an issue of personal safety, to obtain a copy of your protected health information.**
- **The right to request an amendment of your protected health information.**
- **The right to receive an accounting of disclosures of protected health information.**
- **The right to obtain a paper copy of this notice upon request.**

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

- I have received, read and understand your Notice of Privacy Practices

Signature

Date