Registration Form

Procedure Code:	Diagnosis Code:	Date:

Client Name: _____ DOB: _____

Address: _____
Street City State Zip Code

Phone: _____
Home Cell Work

Email: _____

Guardian: _____
if minor Guardian Name Relationship Phone

Can we leave a message?

☐ Yes
☐ No

Gender:

☐ Male
☐ Female
☐ Transgender
☐ Non-Binary
☐ Prefer not to answer

Preferred Pronouns:

☐ He/Him
☐ She/Her
☐ They/Them

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact: _____
Contact Name Relationship Phone

Assignment & Release

I understand and verify that I (or my dependent) have insurance coverage with and sign directly to Mindful Balance Psychological Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Client/Guardian Signature Relationship Date

INSURANCE INFORMATION

PRIMARY INSURANCE ☐ SELF PAY ☐ PRO BONO

Insurance Name: Contract #/ID:

Subscriber's Name: Group #:

Subscriber's DOB: Relationship:

Subscriber's Employer:

SECONDARY INSURANCE

Insurance Name: Contract#/ID:

Subscriber's Name: Group#:

Subscriber's DOB: Relationship:

Subscriber's Employer:

WORKMEN'S COMP / AUTO INSURANCE ONLY

Client Name: Client DOB:

Client Address:

Social Security #: Claim #:

Name of Adjuster: Adjuster's Phone #:

Date of Injury: Name of Employer:
(at time of injury)

HIPPA PRIVACY PRACTICES

I acknowledge that I have reviewed the HIPPA Notice of Privacy Practices.

Client Name (PRINT) Date

Client/Parent/Guardian/Personal Representative Signature Date

If signed by Personal Representative, please describe relationship to client: _____

CONSENT FOR TREATMENT

1. I voluntarily consent to participate in the initial intake and assessment process.
2. I have been given the opportunity for discussion of any concerns that I have regarding treatment.
3. I will be informed and take part in my treatment and goal planning.
4. I understand:
    - That I may withdraw my consent in writing at any time.
    - That I must notify Mindful Balance Psychological Wellness if my insurance carrier or coverage changes.
    - I am responsible for monitoring my insurance. It is my responsibility to ensure participation and non-participation. I am responsible for payment of any services not covered by insurance and will pay any and all charges, co-pays, and deductibles owing Mindful Balance Psychological Wellness in accordance with their regular rates. **Any insurance balance not paid within 120 days will become my responsibility.**
    - Any and all balances will need to be paid off at the time of appointment. Next appointments cannot be made unless balances are paid.
    - If I must cancel an appointment, I am required to contact the office 24 hours prior to the appointment. Voicemail is available 24 hours a day, 7 days a week. **If I fail to contact the office, I will be charged a $50 no-show fee -no exceptions.** This fee is not billable to your insurance, and is due at the beginning of your next session.
    - Balances over 30 days will accrue a service charge of 1.5% monthly, 18% annually. In addition to the above service charge, I agree to pay all costs of collection, including filling fees, court costs, and reasonable attorney fees.
    - **I will be charged $25 for any non-sufficient funds charges on checks.**
    - In case of inclement weather, I am to call the office prior to my appointment to confirm that the office is open. If the office has closed, there will be a message on our recording indicating the closure.
    - If I have a late cancellation, or no-call no-show twice within a one year period, my case will be closed.
    - If my therapist must write a letter(s) or fill out insurance forms, there will be a $15 charge for this service. Also, I must allow up to a week for this service to be completed.

Client/Parent/Guardian/Personal Representative Signature Date

CLIENT HISTORY

Client's Name: _____ DOB: _____

ADULT ONLY
(CHILD ONLY - SKIP TO SECTION 2)

	NAME	SEX	AGE	LIVES WITH YOU	DECEASED
Spouse/ Significant Other					
Children					
Mother					
Father					
Siblings					

EDUCATIONAL BACKGROUND

Highest Level Competed: HIGH SCHOOL TRADE COLLEGE GRADUATE

College Degree: _____ Graduate Degree: _____

Any vocational training: _____

Are you satisfied with your education? Y N
If NO, why not? _____

_____

LEISURE AND RECREATION

List your hobbies and interests: _____

_____

Has your level of activity changed? Y N

If YES, explain: _____

_____

EMPLOYMENT HISTORY

EMPLOYER (MOST RECENT)	DATES	JOB DESCRIPTION

Are you currently employed outside the home? Y N Are you FULL PART

Special circumstances (laid off, medical leave, suspended, retired, other): _____

_____

Do you currently have financial problems? Y N

PHYSICAL HEALTH

Who is your current physician? _____

_____

Address Phone/Fax

Date of last physician appointment: _____ Reason for seeing your physician: _____

_____

List your current medications: _____

_____

_____

PHYSICAL HEALTH CONTINUED

Are you allergic to any medications? Y N

If YES, explain: _____

_____

COUNSELING - PRIOR TREATMENT HISTORY

Have you ever had thoughts of, or attempted, harming yourself or another person? Y N

If YES, explain: _____

_____

Do you have a history of any suicidal attempts? Y N

If YES, explain: _____

_____

Have you had counseling before? Y N

If YES, please provide information below:

NAME OF LOCATION	INPATIENT/OUTPATIENT	DRUG/ALCOHOL TREATMENT?

Other comments: _____

_____

_____

Client Signature Date

SECTION 2
(CHILD ONLY)

Name of person completing this form: _____

Relationship to child: _____

FAMILY HISTORY

	NAME	AGE	EMPLOYER/SCHOOL	MARITAL STATUS
MOTHER				
FATHER				
STEP-PARENTS				
SIBLINGS				

SCHOOL ADJUSTMENT

School District: _____ School Name: _____

Has your child been afraid to go to school? Y N

If YES, explain: _____

(SCHOOL CONTINUED)

Current grade: _____

Repeated any grade(s)? Y N

If YES, explain: _____

_____

Has your child ever had difficulties with:

MATH READING LANGUAGE SPEECH

Has your child ever had special education services? Y N

If YES, explain: _____

_____

Have you received any complaints from your child's school about behavior or achievement? Y N

If YES, explain: _____

_____

How does your child relate to peers? _____

_____

LEISURE

How does your child spend his/her free time? (hobbies)

_____

_____

_____

_____

COUNSELING - PRIOR TREATMENT HISTORY

Has your child ever had thoughts of, or attempted, harming themselves or others? Y N

If YES, explain: _____

_____

Does your child have a history of suicidal attempts? Y N

If YES, explain:

_____

_____

Has your child had counseling before? Y N

If YES, please provide information below:

NAME OF LOCATION	INPATIENT/OUTPATIENT	DRUG/ALCOHOL TREATMENT?

ADJUSTMENT DIFFICULTIES

Please check any that apply to your child:

____Doesn't feel liked
____Feels lonely
____Shy with children
____Prefers to be alone
____Worries
____Moody
____Sad
____Cries easily
____Expects failure
____Doesn't share
____Lacks motivation
____Sexually acting out
____Preoccupied with sexual thoughts
____Ticks or twitches
____Compulsive behavior
____Violent behavior
____Fails to understand consequences
____Ritualistic behavior
____Talks impulsively
____Acts impulsively
____Feelings of guilt
____Doesn't feel like self
____Easily angered
____Stubborn
____Defiant
____Aggressive
____with Peers
____with Siblings
____with Adults
____Needs the "last word"
____Stealing from home
____Stealing from peers
____Will not admit blame
____Destructive to property
____Sets fires
____Poorly organized
____Clumsy
____Takes unnecessary risks
____Short attention span
____Daydreams
____Jealousness
____Overactive
____Poor hygiene
____Sleep difficulties
____Sleep walking
____Bedwetting-present
____Bedwetting-past
____Soiling
____Unusual thinking
____Unusual behavior
____Not always truthful

Other comments: _____

_____

_____

_____

_____

Parent/Guardian Signature Date