ARBOR CLINICAL ASSOCIATES

REGISTRATION INFORMATION

(PLEASE PRINT)

Cell Phone: _____

Date: _____ Home Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: M ____ F _____ Age _____ Date of Birth _____ Email Address _____

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Whom may we thank for referring you? _____

Name of person(s) responsible for this account _____ Relationship to Patient _____

Address Same as Above? Yes _____ No _____ If No, please provide address:

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Patient/Responsible Party Employed By: _____ Work Phone: _____

Business Address: _____

Do you have Medical Insurance? No _____ Yes _____ Medicare _____

Name of Insured: _____ **Insured Date of Birth**: _____

Insurance Company: _____ Address: _____

Phone: _____ Policy #: _____ Group #: _____

In case of emergency, who should be notified: _____ Phone: _____

Purpose of Visit: _____

Known Medical Problems: _____

_____

Religious Affiliation: _____

Signature of Patient: _____

If patient is a minor, I consent for my minor child to be treated at Arbor Clinical Associates.

Signature of parent: _____

Diagnosis Code: _____

Arbor Clinical Associates
Outpatient Services Contract

Welcome to Arbor Clinical Associates. This document contains important information about our professional services and business policies. We ask that you read it carefully and sign it as an acknowledgement of your agreement to abide by these policies.

Psychological Services
Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the patient and the particular problems that the patient brings. There are a number of different approaches that can be utilized for the problems you hope to address. It is not like visiting a medical doctor, in that psychotherapy requires a very active effort on your part. In order to be most successful, you should work on things we talk about both during our sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings. Psychotherapy often requires discussing unpleasant aspects of your life. Psychotherapy has also been shown to have benefits for people who undertake it. However, there are no guarantees about the outcome.

Appointments
If psychotherapy is initiated, you usually schedule 55-60 minute sessions. Once this appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. Missed appointments (or late cancellations) cannot be billed to your insurance and will be billed to you directly.

Insurance Reimbursement
If you have a health insurance policy, it may provide some coverage for mental health treatment. Our office will provide you with whatever assistance it can in facilitating your receipt of the benefits to which you are entitled including filling out forms as appropriate. Bear in mind, though, that you are ultimately responsible for full payment of the fee regardless of whether or not your insurance company has properly or improperly determined payment.

“Managed Health Care Plans” such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. Where possible, this office will assist in obtaining this authorization for you, but it is ultimately your responsibility to make sure you are taking the proper steps to obtain reimbursement from your insurer.

You should also be aware that most insurance agreements require you to authorize your therapist to provide a clinical diagnosis or additional clinical information such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, this office has no control over what they do with it. It is important to remember that you always have the right to pay for services directly and avoid the reporting and complexities associated with insurance coverage.

Contacting Your Therapist
Arbor Clinical Associates has a 24-hour Answering Service. The service will attempt to reach your therapist or an alternate therapist should a crisis occur. Your therapist will not usually accept phone calls while with a client. In case of crisis or emergency, if your therapist or an associate is not available, you should call your family physician or go to the emergency room at the nearest hospital.

When at all possible, fees will be determined prior to service. You will be expected to pay for each session at the time it is held, unless you have insurance coverage that requires another arrangement. Please contact our office if you have any questions about fees.

Confidentiality
In general, the confidentiality of all communications between a client and a psychotherapist is protected by law, and can only be released to others with your written permission. However, there are a few exceptions.

In most judicial proceedings, a judge may order records by subpoena. In some circumstances such as child custody proceedings or in cases which your emotional condition is an important element, a judge may require your therapist's testimony if he/she determines that resolution of the issues before him/her demands it.

There are some situations in which your therapist is legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. For example, if the therapist believes that a child, an elderly person, or a disabled person is being abused, he or she may be required to file a report with the appropriate agency. Also, if the therapist believes that a client is threatening serious bodily harm to another, he or she may be required to take protective actions which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him/herself, your therapist may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection.

While these situations are rare, you should be aware of their possible occurrence. Should such a situation occur, your therapist will make every effort to fully discuss it with you before taking any action.

Your therapist may occasionally find it helpful to consult about a case with another professional. In these consultations, he or she will make every effort to avoid revealing the identity of the client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, your therapist will not tell you about these consultations unless he/she feels it is important to your work together.

Therapist: _____ Date: _____

I acknowledge receipt of this Outpatient Services Contract, which I have read and understood. I further acknowledge that I have had the opportunity to ask questions about the contract with my therapist. By my signature below, I accept the terms of the contract and provide my voluntary consent to treatment as recommended and fully explained to me by the staff of Arbor Clinical Associates. I understand that I am free to withdraw my consent and discontinue treatment at any time.

Client Signature: _____ Date: _____

If Client is a minor,
Parent/Guardian Signature: _____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

Arbor Clinical Associates

I hereby acknowledge I have reviewed the Notice of Privacy Practices. The Notice contains information regarding potential uses and disclosures of my protected health information (defined by the Health Insurance Portability and Accountability Act of 1996) that may be made by Arbor Clinical Associates and of my rights and the practice's legal duties with respect to my protected health insurance information. I may request a copy of the Notice to take with me if I so choose.

_____

Client's Signature

_____

Parent/Guardian Signature

_____

Date

Authorization to Bill Insurance

Patient or Authorized person's signature: I authorize **Arbor Clinical Associates** to submit claims to my insurance company on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed _____ Date _____