

**North Hills Psychological Associates, Inc.**

**REGISTRATION FORM**

(Please Print)

<b>CLIENT INFORMATION</b>						
<b>Client's Last name:</b>	<b>First:</b>	<b>Middle:</b>	<b>Age:</b>	<b>DOB:</b>	<b>Gender associated with insurance:</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Marital status:</b> Single Married Div. Div. Sep. W.
<b>Home phone #:</b>	<b>Mobile phone #:</b>		<b>Work phone #:</b>			
OK to leave message? Yes No	OK to leave message? Yes No		OK to leave message? Yes No			
<b>Street address:</b>						
<b>P.O. Box:</b>	<b>City:</b>		<b>State:</b>	<b>ZIP Code:</b>		
How did you hear about us? (please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend						
<input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Internet <input type="checkbox"/> Other _____						
<b>Whom may we thank for referring you?</b>						
<b>I give my permission for the following friend or relative to be called in case of emergency:</b>		<b>Relationship to Client:</b>	<b>Home phone #:</b>	<b>Mobile phone #:</b>		
<b>FINANCIAL INFORMATION</b>						
I authorize NHPA to charge my credit card for services rendered, if my account becomes delinquent or if my check is returned from the bank. I understand this form is valid for two years unless I cancel the authorization in writing. I agree not to dispute charges ("charge back") for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize NHPA to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.						
<b>Credit Card Company:</b>			<b>Credit Card #:</b>			
<b>Expiration Date:</b>		<b>Name as it appears on card:</b>				
<b>INSURANCE INFORMATION</b>						
(Please give your insurance card and photo ID to the receptionist.)						
<b>Name of primary insurance:</b>						
<b>Subscriber's name:</b>	<b>Subscriber's SS#:</b>	<b>Subscriber's DOB:</b>	<b>Group #:</b>	<b>Policy ID#:</b>		
<b>Employer:</b>			<b>Employer address:</b>			
Client's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____						
<b>Is Client covered by secondary insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Name of secondary insurance:</b>			
<b>Secondary Subscriber's name:</b>	<b>Subscriber's SS#:</b>	<b>Subscriber's DOB:</b>	<b>Group #:</b>	<b>Policy #:</b>		
<b>Employer:</b>			<b>Employer address:</b>			
Client's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
<b>AGREEMENT AND RELEASE</b>						
I assign directly to NHPA, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any balance owed and all services not covered by my insurance. I hereby authorize NHPA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I will keep NHPA current regarding any changes in insurance or contact information. I attest that the above information is true to the best of my knowledge.						
<b>Responsible party signature:</b>						<b>Date:</b>

North Hills Psychological Associates, Inc. (NHPA)  
**CONTRACT AND CONSENT FOR EVALUATION AND TREATMENT**

Client's Name \_\_\_\_\_

I understand that by signing this Agreement I am entering into a contract for NHPA to provide professional services under the following terms and acknowledgements:

1. I will provide the clinical information requested by NHPA to facilitate appropriate treatment.
2. I will work with NHPA to determine a mutually agreeable Treatment Plan and discuss any concerns or questions I have regarding these professional or administrative services.
3. I understand that no promises have been made to me as to the results of treatment provided by NHPA.
4. I will respect my commitment to follow up appointments and keep the appointments that I have scheduled. If I am unable to keep an appointment, I will give at least 24 hours notice. If I do not give this notice, I will be responsible for fees of \$50 for No Show and \$25 for Cancellation without 24 hours notice.
5. I understand that copays are due at the time of service. I will be responsible for payment of a \$10 fee if I do not pay my copay at the time of service.
6. I understand that I may stop my treatment with my clinician at any time. I agree to give my therapist notice of this decision. I will still be responsible for paying for the services I have already received.
7. I will keep NHPA informed of current information about my address, phone numbers and insurance coverage.
8. I authorize direct payment to NHPA of any insurance benefits otherwise payable to me for provided services. I also authorize my insurance company to furnish NHPA information pertaining to my insurance benefits and the status of claims submitted by NHPA for services rendered.
9. I acknowledge that while insurance may cover part of all the fees charged by NHPA, I am ultimately responsible for the cost of the services provided. I understand that benefits quoted are not guaranteed.
10. I will fulfill my responsibilities in keeping any behavioral managed care personnel informed of requested services and comply with their authorization procedures.
11. I consent to the release to my health plan or insurance company, the medical information necessary for NHPA to secure payment for services rendered.
12. I understand that the fees for office services do not include the cost of telephone calls to provide other professional services and I agree to be responsible for the cost of these services at the rate of \$2.38 per minute if more than five minutes.
13. I understand that some behavioral managed care companies want to review complete records of some patients. You may release my records without obtaining an additional release.
14. I authorize NHPA to complain to the Insurance Commissioner for any reason on my behalf.
15. My primary Care Physician, Doctor \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_ Phone # \_\_\_\_\_ is responsible for my

medical care (or the medical care of my child). You may inform this doctor of the diagnosis and treatments provided by NHPA. I authorize NHPA:

- To exchange any applicable information with my Primary Care Physician and their office  
 Not to release information to my Primary Care Physician

16. NHPA may leave messages regarding appointments on my home answering machine and/or voicemail.
17. I have received the Notice of Privacy Practice and the NHPA Service Brochure.
18. I understand that if my account becomes delinquent, a rebilling fee of \$3.00 per month will be assessed and my account could be sent to collections.
19. I understand that NHPA does not do evaluations or recommendations for the legal system. (Also, if this contract is for my child, I am aware that requesting the release of treatment plans, notes or reports for forensic purposes, or subpoenaing testimony about any of the content of my child's treatment interferes with the therapy relationship and greatly jeopardizes his/her health and wellbeing.) Therefore, I knowingly and freely waive my right to request the release of information (other than dates of sessions, length of sessions, attendance at sessions, and fee information) to my attorney or the Court. I understand that release of clinically-significant information to the Court shall be by Court Order, signed by a duly appointed Judge, only. I further understand, that if I violate this agreement and attempt to involve the therapist in a court/custody dispute, I will be billed for the therapist's time for these legal issues, at a rate of \$4.76 per minute, including, but not limited to, responding to attorneys, phone calls, writing reports, supervision, preparing for court appearances, travel to and from court, etc. I understand that payment for these charges is the responsibility of the client or parent/guardian requesting them, regardless of any custody order.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Client or person authorized to sign for client

## ADULT CHECKLIST OF CONCERNS

Name: \_\_\_\_\_

Date: \_\_\_\_\_

*Please mark all the items below that apply, and feel free to add any others at the bottom under “Any other concerns or issues.” You may add a note or details in the space next to the concerns checked.*

- I have no problem or concern bringing me here
- Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use—prescription medications, over-the-counter medications, street drugs
- Eating problems—overeating, undereating, appetite, vomiting (see also “Weight and diet issues”)
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Gender, sexual orientation
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores—quality, schedules, sharing duties
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits

**OVER**

- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection
- Panic or anxiety attacks
- Parenting, child management, single parenthood
- Perfectionism
- Pessimism
- Procrastination, work inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- School problems (see also “Career concerns . . . ”)
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)
- Shyness, oversensitivity to criticism
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Social Media Concerns
- Spiritual, religious, moral, ethical issues
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolating
- Work problems, employment, workaholism/overworking, can’t keep a job, dissatisfaction, ambition

Any other concerns or issues:

\_\_\_\_\_

\_\_\_\_\_

Please look back over the concerns you have checked off and choose the one that you most want help with.

It is: \_\_\_\_\_