



HUNTSVILLE
PSYCHOTHERAPY
& COUNSELING
SERVICES

Today's Date: ___/___/___

Name of Therapist: _____

Patient Registration Form

Full Name of Client: _____ Date of Birth: ___/___/___ Age: ___ Gender: M F

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

Home Phone: _____ Work Phone: _____

*Cell Phone: _____ *Email: _____

*By providing my cell phone number, I agree that Huntsville Psychotherapy & Counseling Services may contact me by cell phone call and text message. By providing my e-mail address, I agree to receive future communications via e-mail from Huntsville Psychotherapy & Counseling Services, unless I elect otherwise.

Please **exclude** my e-mail address from any communications from Huntsville Psychotherapy & Counseling Services (HPCS).

Marital Status: M S D W Patient's Education Level: _____ Occupation: _____

Employer: _____

If patient is a minor, please complete the following:

Mother's Full Name: _____ Social Security Number: ____-____-____

Mother's Employer: _____ Work Phone: _____

Father's Full Name: _____ Social Security Number: ____-____-____

Father's Employer: _____ Work Phone: _____

If patient is a student, his/her grade level: _____ School: _____

Referred By: _____

Responsible party for payment of services: _____

Address of Responsible Party if different than patient: _____

Primary Insurance Information:

Insurance Company: _____ Policy Number: _____ Group: _____

Insured's Name: _____ Employer: _____

Insured's Birth Date: ___/___/___ Insured's Social Security Number: ____-____-____

Emergency Contact Information:

Name: _____ Relationship: _____

Home Phone: _____ Other Phone: _____

Payment Policy

This notice is to inform you of our payment policies here at Huntsville Psychotherapy & Counseling Services. Our policy is full payment at the time services are rendered. We accept the following forms of payment, Cash, Check, Visa, MasterCard, American Express, and Discover.

A reminder text will be sent to the number you specified to us ONE DAY PRIOR to your upcoming appointment. For phone calls please note that if we do not reach a person, we will leave a voice mail. We do require that cancellations be made at least 24 hours before your scheduled appointment. Please also note that missed appointments, reports, or correspondence is not covered by your insurance company. You will be responsible for covering the cost of your therapist's time.

- _____ I understand that for late cancellations (less than 24 hours notice) or if I fail to show up to my appointment I will be charged **\$90.00 FOR THAT MISSED APPOINTMENT** or \$60.00 for a Late Cancellation.
- _____ Returned checks will incur a **\$60** service charge
- _____ I understand that text reminders are sent as a courtesy and cancellation by phone is required
- _____ Any reports / correspondence required of therapist may be subject to a fee commensurate with the preparation time.

PLEASE NOTE THAT WE ARE NOT RESPONSIBLE FOR TEXT CANCELLATIONS SENT BUT NOT RECEIVED AND CHARGES MAY APPLY.

We will be pleased to file your **primary insurance** for your convenience. We will provide you with a complete itemized statement in order for you to file your secondary insurance. If you would like for us to file your primary insurance, all deductibles and copayments will be required at time of visit.

- _____ I understand that I, the patient/responsible party, will be responsible for **payments in full** regardless of amounts compensated by my insurance company. Should my account be turned over to an attorney/collection agency for nonpayment, I will be responsible for additional attorney/collection fees as well.
- _____ I authorize Huntsville Psychotherapy & Counseling Services to file insurance on my behalf and provide my insurance company any necessary information. I also authorize payment to be made directly to Huntsville Psychotherapy & Counseling Services.

Limitations on Confidential Nature of Communications

Communications between a licensed psychologist, psychiatrist, or a licensed professional counselor and the patient are confidential and will not be released without the expressed authorization of the patient. However, certain communications may occur where confidentiality is limited. They are as follows:

- Should a provider believe the patient is a threat to others or themselves
- When records are ordered to be released by a Judge or Court
- When information involves child abuse or abuse of the elderly
- When information is given about the transmission of contagious or transmittable diseases
- Should the patient's account be turned over to an attorney/collection agency for non-payment

I acknowledge that I understand and agree to the above payment policy and limitations of confidentiality.

Patient/Parent/Responsible Party

Date

Office Staff

Date

NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS

We, Huntsville Psychotherapy & Counseling Services, are required by federal and state law to maintain the privacy of your health information. We are also required to provide you with this notice about our responsibilities in respect to your health information. We reserve the right to change our privacy practices and the terms of this notice at any time, and those changes are permitted applicable by law. Before any changes are made, we will provide this notice and make the new notice available upon request. This notice describes how any health information about you may be used and disclosed and how you can get access to this information. You have rights to your health record at any time. You may request that we provide copies to you of this record, which we will be happy to provide to you at a minimal cost. Please review this notice carefully and if you have any questions please feel free to contact any office staff.

Uses and Disclosures of Protected Health Information (PHI)

Protected Health Information, also known as PHI, includes information such as: name, address, insurance information, etc. that can be used to identify you. It is information about your past, present and future health condition or payment for healthcare. Huntsville Psychotherapy & Counseling Services will not use or disclose any more of your PHI as necessary to accomplish the intended purpose. We are legally required to follow the privacy practices that are described in this notice.

Examples of the uses and disclosure are listed below:

Treatment: We may use or disclose your PHI to a physician, other healthcare provider or your insurance to provide treatment for you.

Payment: We may use and disclose your information to obtain payment for services we provide to you.

Healthcare Operations: We may use your PHI for your healthcare operations. This includes evaluating the quality of healthcare services, reviewing competencies or qualifications of healthcare personnel, conducting training programs, accreditation, certification and/or credentialing activities. Huntsville Psychotherapy & Counseling Services may also provide your PHI to our accountants, attorneys, consultants, health improvement agencies and others in order to make sure that we comply with all laws.

Patient Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to disclose your PHI to anyone for any purpose. You may revoke an authorization at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. However, unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the notice.

Family and Friends: We will only disclose your health information to your family and friends to the extent necessary to help with your healthcare ONLY if you have given us permission to do so.

Abuse or Neglect: We may disclose your health information to appropriate health authorities if we have reasonable belief that you are possibly a victim of abuse, neglect, domestic violence or if we feel as though you are a threat to yourself or others.

Report Complaints and Privacy Violations: If you feel that we at any time have not responded to your concerns, you may contact our staff. All patient concerns will be handled courteously and promptly. You also have the right to contact the US Department of Health and Human Resources or the Alabama Department of Public Health.

Signature: _____ Date: _____

Office Staff: _____ Date: _____

Symptom Checklist

Name: _____

Date: _____

Please CHECK as many of the following items which apply to you. Do you have trouble with:

<p>SLEEP PROBLEMS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty Falling Asleep <input type="checkbox"/> Early morning waking <input type="checkbox"/> Waking during the night <input type="checkbox"/> Feel tired when waking <input type="checkbox"/> Increase in dreams <input type="checkbox"/> Unpleasant dreams <input type="checkbox"/> Excessive sleep <p>CHANGES IN:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Weight ____ lbs lost/gained <input type="checkbox"/> Health <input type="checkbox"/> Sexual interest <input type="checkbox"/> Sexual performance <input type="checkbox"/> Appetite <input type="checkbox"/> Energy level <p>FEELINGS OF:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Tiredness <input type="checkbox"/> Boredom <input type="checkbox"/> Lack of interest <input type="checkbox"/> Sadness <input type="checkbox"/> Depression <input type="checkbox"/> Despair <input type="checkbox"/> Worthlessness <input type="checkbox"/> Helplessness <input type="checkbox"/> Emptiness <input type="checkbox"/> Rage <input type="checkbox"/> Tension <input type="checkbox"/> Loneliness <input type="checkbox"/> Guilt <input type="checkbox"/> Hopelessness <p>THOUGHTS OF:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Harming yourself <input type="checkbox"/> Harming others <p>DO YOU HAVE ALLERGIES?</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes 	<p>RECENT HISTORY OF:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever/chills <input type="checkbox"/> Sweating <input type="checkbox"/> Chest pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Trembling <input type="checkbox"/> Lower back pain <input type="checkbox"/> Dry mouth <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Palpitations <input type="checkbox"/> Rapid breathing <input type="checkbox"/> Head injury <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Loss of memory <input type="checkbox"/> Confusion <input type="checkbox"/> Seizure <input type="checkbox"/> Bleeding <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Numbness, tingling <input type="checkbox"/> Paralysis <input type="checkbox"/> Flashbacks <input type="checkbox"/> Blackouts <p>DIFFICULTY WITH:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Short attention span <input type="checkbox"/> Carelessness or sloppy work <input type="checkbox"/> Listening when spoken to <input type="checkbox"/> Following through on instructions <input type="checkbox"/> Organizing tasks or activities <input type="checkbox"/> Avoiding homework or paperwork <input type="checkbox"/> Losing things at home or school <input type="checkbox"/> Forgetfulness in daily activities <input type="checkbox"/> Fidgeting or squirming in seat <input type="checkbox"/> Sitting still <input type="checkbox"/> Restlessness or hyperactivity <input type="checkbox"/> Playing quietly <input type="checkbox"/> Talking excessively <input type="checkbox"/> Speaking out of turn <input type="checkbox"/> Waiting for others <input type="checkbox"/> Interrupting or intruding on others 	<p>CONFLICT WITH:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Spouse <input type="checkbox"/> Family member <input type="checkbox"/> Other loved one <p>PROBLEMS WITH:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arguing a lot <input type="checkbox"/> Lying <input type="checkbox"/> Stealing <input type="checkbox"/> Losing Temper <input type="checkbox"/> Avoiding people <input type="checkbox"/> Spending/finances <input type="checkbox"/> Sexual behavior <input type="checkbox"/> Gambling <input type="checkbox"/> Eating <input type="checkbox"/> Fighting <input type="checkbox"/> Increased drinking <input type="checkbox"/> Substance abuse <input type="checkbox"/> Destroying things <p>FEAR OF:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of control <input type="checkbox"/> Death <input type="checkbox"/> Being alone <input type="checkbox"/> Places/situations <input type="checkbox"/> Objects or animals <input type="checkbox"/> Cancer <input type="checkbox"/> AIDS <input type="checkbox"/> Being possessed <input type="checkbox"/> Being insane <p>EXPERIENCE OF:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vivid dreams <input type="checkbox"/> Nightmares <input type="checkbox"/> Hearing voices <input type="checkbox"/> Seeing visions <input type="checkbox"/> Being out of body
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Thank you for taking the time to complete this form!

Please note that your individual therapist works with a group of independent mental health professionals, under the name Huntsville Psychotherapy & Counseling Services, LLC. This group is an association of independently practicing professionals who share certain expenses and administrative functions. While the members share a name and office space, please know that your therapist is completely independent in providing you with clinical services, and she/he alone is fully responsible for those services. His/hers professional records are separately maintained and no member of the group can have access to them without your specific written permission.

Email Security Statement

- Huntsville Psychotherapy & Counseling Services makes every attempt to safeguard the security and confidentiality of any email transmission.
- Because of many factors beyond our control, we cannot be responsible for misaddressed, misdelivered, or interrupted email.
- Neither your therapist nor Huntsville Psychotherapy & Counseling Services can be held liable for breaches of confidentiality caused by yourself or a third party.
- Any email, especially those that address treatment or diagnosis, can be made a part of your permanent chart.
- Your provider may forward your email to other staff for administrative matters, such as requests for appointment changes; however, your email will never be forwarded outside the office.
- In order to prevent the introduction of computer viruses, we reserve the right not to open emails or attachments.

- I have read and understand the possible concerns surrounding use of email in this setting.
- I accept the risks noted above, and consent to allowing my therapist to send emails regarding appointments, and other issues as needed.
- Email is best suited for routine matters and simple questions. Clinical issues are to be reserved for in-office appointments. Do not expect an immediate response to your email. Response time will vary depending on your therapist's schedule.**

Preferred email address:

Treatment, Compliance and Termination Statement

- In addition to the no-show and cancellation policy addressed in HPCS paperwork, I understand I may be charged if I miss multiple appointments in a short period of time, even if cancelled with appropriate notice. Consistency in therapy is important, and I will have the chance to address any questions or concerns with my therapist.
- I understand and acknowledge that if I have no face to face contact with my therapist for 90 days, my chart will be transitioned to closed status. I understand I would still be **able to return** for services, but may have to complete a second diagnostic interview.

Signature of Client/Responsible Party: _____ Date: _____

Witness: _____ Date: _____

Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Huntsville Psychotherapy & Counseling Services mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have these rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. HPCS utilizes secure, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to “face-to-face” psychotherapy.
6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

8. I understand that my express consent is required to forward my personally identifiable information to a third party.

9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services

HUNTSVILLE PSYCHOTHERAPY & COUNSELING SERVICES will bill insurance for telehealth services when these services have been determined to be covered by an individual’s insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, a prompt pay discount is available. We will provide you with a statement of service to submit to your insurance company if you wish.

Patient Consent to the Use of Telehealth I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Print Name

Client’s Signature Date

Parent or Guardian Signature Date