

Shelby Psychological Services Adult Patient Registration Form

PATIENT INFORMATION					
Name		Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	
Street Address		City		State	Zip Code
School (if applicable)	Grade	Employer		Work Phone ()	
Email Address				Home Phone ()	
Primary Care Physician Name:				Cell Phone ()	
How Did you Hear About Us? <input type="checkbox"/> Physician <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance Co. <input type="checkbox"/> Other _____					
INSURANCE INFORMATION			(Please provide your insurance card for office to copy)		
Primary Insurance			Primary Policyholder's (PP's) Name		
Primary Policyholder's Social Security #	PP's Birth Date	PP's Employer		Group number	
Policy Number		Patient's Relationship to Primary Policyholder			
Secondary Insurance					
Primary Policyholder's Name		PP's Birth Date	PP's Employer		Group number
Policy Number		Patient's Relationship to Primary Policyholder			
Person Responsible for Bill and address if different					
Your Signature					

- Acknowledges:
- ✦ Accuracy of above information and financial responsibility to pay any balance and attorney if required for account collection
 - ✦ Notice of HIPAA and State of Alabama policy and practices to protect your health information
 - ✦ Consent for me or my minor child to be evaluated and/or treated by Shelby Psychological Services
 - ✦ Dr. Vance has a small therapy-dog-in-training at SPS – we understand it is our responsibility to inform SPS staff if we do not want to interact with the dog.

- Authorizes:
- ✦ SPS to release information required to process my insurance claim and for insurance benefits to be paid to SPS
 - ✦ Consent to release treatment information to SPS providers only in the event of an interoffice referral
 - ✦ Consent to release requested information to the referring physician/source
 - ✦ Consent to release information for insurance purposes, when required, with supervising providers.

I have read, understand and acknowledge/authorize the above.

Printed Name of Patient/Guardian _____

Signature of Patient/Guardian

Date

**Shelby Psychological Services
FINANCIAL AGREEMENT**

Patient/Guardian/Responsible Party Name:

Please remember that insurance is considered a method of reimbursing the patient for the fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Testing services are not always reimbursed. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL THE COST OF BILLINGS, IT IS REQUESTED THAT THE CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF THE VISIT. APPOINTMENTS NOT CANCELED 24 HOURS PRIOR TO THE SCHEDULED TIME WILL BE CHARGED AT THE REGULAR RATE. Automated reminder calls are sent out as a courtesy. However, computers do sometimes malfunction and phone numbers change etc. **YOU ARE STILL RESPONSIBLE TO KEEP YOUR APPOINTMENTS OR CANCEL ON A TIMELY BASIS** even if the reminder system does not work.

_____ Please initial

If a provider receives a subpoena with an order to appear for court proceedings regarding this case, it is the client/guardian's responsibility to reimburse the provider for their time. This includes preparation time, travel time and actual time at court at the cost of \$200/hour. A retainer fee of \$1000 is required at the time of the request. _____ Please initial

If this account is assigned to an attorney for collection and/or suit, I agree to pay a reasonable attorney's fee and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits, to include any major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and/or other health plans to Shelby Psychological Services.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Responsible Party Signature _____ Date _____

Notice of Privacy Practices

Client Name _____

This notice describes how Medical/Mental Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective 01/01/2014. Milkay Counseling Services will only release information in accordance with state and federal laws and the ethics of the counseling profession. The following describes policies related to the disclosure of client's healthcare information. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality of care. State and Federal Laws allow Milkay Counseling Services to use and disclose health information for these purposes.

USES and DISCLOSURES

- *Help manage the health care treatment you receive* – Example: A psychiatrist sends information about your diagnosis and treatment plan so additions or changes in your care can be provided
- *Payment* – Example: Verifying your insurance coverage or processing claims to collect fees
- *Healthcare operations* – Example: Site review for compliance
- *Other uses and disclosures without your consent* – Example: Mandated reporting to a suspected crime or abuse

CLIENT RIGHTS

- Right to request where to contact or notify you

Home	___YES	___NO
Work	___YES	___NO
Cell	___YES	___NO
Email	___YES	___NO
Voice Mail	___YES	___NO

Number or email to use:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask to limit the information shared
- Get a list of those with whom your information has been shared
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You can complain if you feel we have violated your rights by contacting Joanna Milkay with Milkay Counseling Services, LLC. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. I will not retaliate against you for filing a complaint.

Milkay Counseling Responsibilities include: 1. Required to maintain the privacy and security of your protected health information 2. Let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3. Follow the duties and privacy practices described in this notice and give you a copy of it. 4. Not use or share your information other than as described here unless you inform Milkay Counseling Services, LLC in writing. If you inform in writing, you may change your mind at any time. Inform Milkay Counseling Services, LLC in writing if you change your mind.

Client Signature (age 14 & up) _____ Date ____/____/____

Guardian Signature _____ Date ____/____/____

Client Name: _____ Date: _____

History

Presenting Issue that brings you to counseling: _____

How long has this been an issue? _____ How intense is the problem? (1=not intense; 10=very intense) _____

List any Diagnosis (treated, resolved, re-occurring etc.) _____

What goals would you like to achieve through counseling? _____

Psychiatric History

I have received treatment for: Substance Abuse Mental Health Issues Both

The treatment occurred at:

Private Psychiatrist Hospital Private Counselor/Therapist

Mental Health Center Other

Present Treatment: Yes No By Whom: _____

Family History

Parent's marital status (*circle one*): Single Married Separated Divorced Deceased

Psychiatric History for you or someone in your family: _____

Have you ever been hospitalized for a mental illness? Yes No If YES, please explain what happened and where _____

Is there a history of substance abuse in the family? If yes please explain: _____

Is there a history of abuse/domestic violence in the family? If yes please explain: _____

Any significant medical history or trauma? _____

Court, Legal or Social Service History

Are you or your family involved with DHR, or have history with DHR or court custody issues? _____

Judge: _____ DHR Worker and Number: _____

Do you have a current legal case pending? _____

Attorney: _____ Judge: _____

CHECKLIST OF CONCERNS

(please check any relevant concerns that apply currently or within the past 3 months)

THOUGHTS/FEELINGS/MOOD

- Anger/frustration/hostility
- Anxiety, nervousness
- Attention, concentration, distractibility
- Confusion
- Depression
- Disliking others
- Emptiness
- Euphoria
- Excessive worry
- Failure
- Fatigue
- Fear
- Grieving (death, loss, divorce, etc)
- Guilt
- Hearing things other people don't
- Homicidal thoughts
- Intrusive thoughts
- Judgment problems
- Memory difficulties
- Negative thoughts
- Obsessive thoughts
- Oversensitivity to criticism
- Oversensitivity to rejection
- Panic attacks
- Perfectionism
- Sadness
- Seeing things other people don't
- Self-centeredness
- Self-esteem (low)
- Shyness
- Spiritual, religious, or moral issues
- Stress
- Sudden mood changes
- Suicidal thoughts
- Suspiciousness
- Temper problems
- Thoughts of hurting self or others

BEHAVIOR

- Aggression, violence
- Alcohol use
- Argumentative
- Avoidant
- Compulsive behavior/rituals
- Controlling
- Decreased/lack of sexual interest
- Dependency
- Destruction of property
- Drug use: prescription, over-the-counter, street
- Eating problems
- Financial problems, debt
- Gambling
- Hyperactivity
- Internet problems
- Irresponsibility
- Isolation
- Legal problems
- Letting others take advantage of you
- Lying
- Not able to relax
- Preoccupation with sex
- Procrastination
- Purging
- History of running away
- Self destruction/sabotaging
- Self-neglect
- Sexual dysfunction
- Smoking
- Stealing
- Threats
- Weight, gain/loss
- Withdrawal from others
- Loss of interest in what I used to like
- Sleep difficulty
- Loss of appetite
- Overeating

FAMILY & RELATIONSHIPS

- Affair
- Childhood issues (client's childhood)
- Divorce
- Friendships
- Housework/chores
- Interpersonal conflicts
- Parenting
- Problems with child(ren)
- Problems with parents
- Problems with spouse/partner
- Separation

ABUSE

- Abuse of alcohol
- Abuse of drugs
- Physical abuse by another
- Physical abuse of another
- Sexual abuse by another
- Sexual abuse of another

WORK & SCHOOL

- Absenteeism
- Career concerns, goals, choices
- Difficulty with coworkers
- Difficulty with supervisor
- Performance
- Tardiness
- Procrastination
- School problems

OTHER CONCERNS

- | | | |
|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Client Informed Consent, Limits of Confidentiality, and Treatment Agreement

BACKGROUND

Welcome to my practice. I have provided services to clients since 2003, after receiving my Master's degree from The University of Montevallo. I became licensed in 2006. My experience includes couples counseling, family counseling, child and adolescent counseling with play therapy modalities, individual and group counseling, and specific training with trauma and abuse. I am trained to provide evidence based therapy in Trauma Focused Cognitive Behavioral Therapy and Eye Movement Desensitization and Reprocessing (EMDR) therapy.

COUNSELING RISKS and EXPECTATIONS

It is natural to want change, to expect change, but it is hard to make change. Counseling is not a quick fix. Counseling requires desire, work, and trust. It is my belief that every person deserves the highest quality of counseling services possible without prejudice to race, gender, religion, physical challenge, ethnic origin or level of income. You may be uncomfortable or have feelings of distress during phases of the relationship. This is normal and part of the process of counseling. It is important for you to know that this may occur, so that you will maintain contact with your counselor long enough to benefit. Counseling is not always successful; some benefit and others do not. Counseling can be productive with an outcome that is beneficial. Please be aware that counseling is a choice and you may choose whether or not to participate. If you choose to participate in counseling, you may choose to terminate at any point in the process. I may choose to terminate the relationship too if there are ethical or other professional situations that warrant termination. This type of termination may not be in agreement but in the best interest of one or both parties. There are some requirements and expectations that we will discuss and agree upon before beginning services. Initially, I will assess the needs and issues for counseling and we will determine the goals. If at any point I determine that I am not able to provide the services that will meet your needs and goals then we will discuss referral sources that may better serve you.

CONFIDENTIALITY/PRIVACY

Another essential aspect of counseling is confidentiality. You need to know that the things discussed in counseling are private and confidential and that your counselor is ethically bound to protect your right to privacy. There are, however, a few circumstances under which details about your counseling will be discussed.

1. Client Safety

- Risk of suicide
- Risk of hurting others
- Risk to the client by someone else (Suspected abuse mandates a report)

2. Court Order

Note: I do not believe that counseling records belong in court. Counseling is confidential and should be honored as confidential and protected. I do not provide custody evaluations or evaluations for court deposition. If you choose to have records subpoenaed and/or require my professional time with your court case, I will charge the legal fees to you in order to get it quashed or before a judge for in court review. Records that are court ordered by a judge require release of records and fees for court include time with paperwork, travel time, time in court and legal fees.

3. Client consents for the release of information to another provider or individual

If a third party pays for your care, such as Blue Cross/Blue Shield or any other insurance company, then that 3rd party has the right to review your record of treatment. By electing to use your insurance, you are choosing to disclose limited information (diagnosis required by insurance companies) to your insurance for the purpose of payment to Milkay Counseling Services, LLC. Release of records or sharing of information requires your consent and documentation as to whom the information can be released or shared. Records are secured for at least 7 years before they are destroyed.

TECHNOLOGY

You may elect to use technology such as email and I take every precaution to protect you and your information from the public. I cannot guarantee unauthorized access with electronic communications. I do not accept friend requests of any clients on Facebook.

CANCELLATION

Your insurance may or may not pay for counseling services. You are responsible for copays and denied insurance submittals. You are responsible for all fees at the time of each appointment. I accept cash, checks, and credit cards. If you refuse to pay your debt, I reserve the right to use an attorney of collection agency to secure payment.

I ask that you please call with a **24 hour** notice to cancel your appointment. Any missed session without cancellation is subject to payment (unless we both agree that the absence was due to circumstances beyond your control). Insurance companies do not reimburse for missed sessions or coming late; you will be responsible for fees incurred, which is the charge of the regular rate for counseling services. An automatic electronic system will remind you of your appointments but sometimes these systems malfunction. You are still responsible and agree to scheduling and cancellation, which can be done through phone and/or email.

AFTER HOURS

Milkay Counseling Services, LLC does not provide on-call services directly. I am available during normal business hours. I check my email and phone regularly to respond to calls that can be attended to within a 24 to 48 hour period. Immediate crisis are directed to THE CRISIS CENTER at **(205) 323-7777** or 1 800 273-8255.

MINORS (children under the age of 14 or adult that can't consent and has a legal guardian)

If you are signing for a minor for whom you are the legal guardian, you are stating that you have the legal right to sign this consent for them and agree to counseling/treatment. The minor is the client. The confidentiality of the session is important. As the custodian, you are entitled to know if the minor is progressing, declining, unstable, in need of further services, or in an unsafe or concerning situation. If you are actively involved in a custody dispute or have legal counsel, I will not speak to an attorney that does not represent the minor client. I will collaborate or consult with a Guardian Ad Litem, representing a minor client, to whom I am counseling and to support the best interest of the minor.

By signing below, you agree to the above conditions and acknowledge that these conditions have been discussed and explained fully to you for the counseling relationship between

CLIENT

and Joanna Milkay, NCC, LPC-S
Milkay Counseling Services, LLC

Client Signature (14 years of age or older)

Counselor Signature

DATE

DATE

Custodial Care

PARENT/GUARDIAN SIGNATURE

PARENT/GUARDIAN SIGNATURE

DATE

DATE