EMPOWER
BEHAVIORAL HEALTH LLC

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 Empower Behavioral Health 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 Empower Behavioral Health unless I elect otherwise.

☐ Please **exclude** my e-mail address from any communications from Empower Behavioral Health.

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: _____ Work Phone: _____

Payment Policy

This notice is to inform you of our payment policies here at Empower Behavioral Health. 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 THREE DAYS PRIOR and then 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 I will be charged **$30** (less than 24 hrs notice).
- _____ I understand that there will be a MINIMUM charge of **$60** if I fail to show up to my appointment.
- _____ Returned checks will incur a **$30** 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 Empower Behavioral Health to file insurance on my behalf and provide my insurance company any necessary information. I also authorize payment to be made directly to Empower Behavioral Health.

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, Empower Behavioral Health, 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. Empower Behavioral Health 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. Empower Behavioral Health 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:

SLEEP PROBLEMS:
□ Difficulty Falling Asleep
□ Early morning waking
□ Waking during the night
□ Feel tired when waking
□ Increase in dreams
□ Unpleasant dreams
□ Excessive sleep

CHANGES IN:
□ Weight ____ lbs lost/gained
□ Health
□ Sexual interest
□ Sexual performance
□ Appetite
□ Energy level

FEELINGS OF:
□ Anxiety
□ Tiredness
□ Boredom
□ Lack of interest
□ Sadness
□ Depression
□ Despair
□ Worthlessness
□ Helplessness
□ Emptiness
□ Rage
□ Tension
□ Loneliness
□ Guilt
□ Hopelessness

THOUGHTS OF:
□ Harming yourself
□ Harming others

DO YOU HAVE ALLERGIES?
□ No
□ Yes

RECENT HISTORY OF:
□ Nausea/vomiting
□ Diarrhea
□ Fever/chills
□ Sweating
□ Chest pain
□ Dizziness
□ Headaches
□ Trembling
□ Lower back pain
□ Dry mouth
□ Shortness of breath
□ Palpitations
□ Rapid breathing
□ Head injury
□ Loss of consciousness
□ Loss of memory
□ Confusion
□ Seizure
□ Bleeding
□ Swollen Joints
□ Numbness, tingling
□ Paralysis
□ Flashbacks
□ Blackouts

DIFFICULTY WITH:
□ Short attention span
□ Carelessness or sloppy work
□ Listening when spoken to
□ Following through on instructions
□ Organizing tasks or activities
□ Avoiding homework or paperwork
□ Losing things at home or school
□ Forgetfulness in daily activities
□ Fidgeting or squirming in seat
□ Sitting still
□ Restlessness or hyperactivity
□ Playing quietly
□ Talking excessively
□ Speaking out of turn
□ Waiting for others
□ Interrupting or intruding on others

CONFLICT WITH:
□ Spouse
□ Family member
□ Other loved one

PROBLEMS WITH:
□ Arguing a lot
□ Lying
□ Stealing
□ Losing Temper
□ Avoiding people
□ Spending/finances
□ Sexual behavior
□ Gambling
□ Eating
□ Fighting
□ Increased drinking
□ Substance abuse
□ Destroying things

FEAR OF:
□ Loss of control
□ Death
□ Being alone
□ Places/situations
□ Objects or animals
□ Cancer
□ AIDS
□ Being possessed
□ Being insane

EXPERIENCE OF:
□ Vivid dreams
□ Nightmares
□ Hearing voices
□ Seeing visions
□ 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 Empower Behavioral Health, 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

- **Empower Behavioral Health cannot guarantee 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 Empower Behavioral Health can be held liable for breaches of confidentiality caused by yourself or a third party.
- Email is best suited for routine matters and simple questions. You should not send email requesting an immediate response. Response time will vary depending on your needs and the therapist's schedule.
- 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.

Preferred email address:

_____

Treatment, Compliance and Termination Statement

☐ In addition to the no-show and cancellation policy addressed in Empower's 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:_____