PRICE COUNSELING CENTER

Christy Cushing, L.P.C.

NEW CLIENT REGISTRATION

This information on this page is for billing and accounting purposes only. Please read the page concerning our policies on patient confidentiality which follows this. Please fill in the requested information or circle the appropriate responses. Thank you.

Patient's name ______________________________ Date __________
(Last) (First) (M)
Address ____________________ City ______________ Zip __________
Phone number(s) Home (___) __________ Work (___)__________ Cell (___) __________
Marital Status: Married/Single/Sep/Div Gender: Male/Female
Student: Full/Part/NA Age ______ Date of Birth __________
Social Security Number ______________ Employed: Full time/Part Time/Not Applicable
Employers name ______________________________
Work Address ______________ City ____________ State _____ Zip __________
How did you hear of us? ______________________________
May we thank them for the referral? Yes ________ No ________

If Patient Is a Child or Minor, We Need the Following Information

Mother's Name/or Guardian ______________________________
Address (if different from above) ______________________________
City ______________ State ________ Zip ______________
Phone Numbers: Work ____________ -Ext ______ Home ____________
Social Security Number ______________ Employed : Full Time/Part Time/ NA
Employer's name and address ______________________________

Father's Name ______________________________
Address (if different from patient's) ______________________________
City ______________ State ________ Zip ______________
Phone Numbers: Work ____________ - Ext ______ Home ____________
Social Security Number ______________ Employed : Full Time/Part Time/ NA
Employer's name and address ______________________________

If Parents live at separate addresses, which address do we use for statements? Mother / Father
** Please note that both parents will be held responsible for account balances. If there is a copayment or fee due at the time of service, the parent bringing the child to the visit will need to make the payment.

Insurance Information

Name of insured person ______________ Relationship to patient: Self/Spouse/Child/Other
Address of insured person: Same as patient's mother/father
Insured's social security number ______________ Date of Birth __________ Gender: M/F
Name of employer (or group) insurance is supplied through ______________________________
Insurance Company Name ______________________________
Address ______________ City ____________ State _____ Zip __________
ID# ______________ Group/Plan # ______________
Phone number to verify benefits ______________________________

** We must make a copy of all insurance cards before we will accept assignment.

Patient's Name ____
(Last) (First) (Middle)

Medical Information

Patient's Physician ______________________________ Phone # ________________

Physician's Address ________________ City ____________ State ______ Zip ________

List any current medical or health problems: ______________________________

____

List any medications that you are currently taking or have taken in the past six (6) months. Also please indicate for which conditions you are taking the medications and the name of the physician who prescribed the medications:

____

____

Personal Information

Your educational level: ______________________________ Degrees: ________________

List any other person(s) residing in household:

Name	Age	Relationship to patient

Patient's Nearest Relative not living in home (in case of emergency)

Name: ________________________ Relation: ______________ Home Phone ____________

Address: __________________________ City ____________ State ________ Zip ________

Brief History

Do you now or have you ever experienced the following to the point where you feel troubled or bothered? (Please Circle)

Alcohol Abuse/addictions	Poor Concentration	Hopelessness	Sleeplessness
Recent Life-style Change	Very Low Energy	Divorce	Poor Memory
Death of a Spouse	Homicidal Thoughts	Legal Problems	Disorientation
Anxiety	Drug Abuse	Excess Stress	Paranoid Feeling
Sexual Dysfunction	Panic Attacks	Depression	Work Problems
Vocational Problems	Aggressiveness	Marital Problems	Hallucinations
Suicidal Thoughts	Confusion	Poor Appetite	Strong Fears
Restlessness			

Has any of your family ever experienced any of the above items to the point that professional attention was sought? Yes______ No ________ If yes, please explain: ____________________

____

Have you ever received counseling or psychotherapy before? Yes ________ No ________

If yes, where? ____

For what reason? ____

Do you feel like you benefitted from this experience? Yes ________ No ________

Name of Counselor/Therapist/Psychiatrist seen previously: ____________________

What issues/problems/concerns might we assist you with at this time? (Use reverse side if necessary)

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____

____

PLEASE READ CAREFULLY AND SIGN THE STATEMENT THAT FOLLOWS

Payment Policy

If you haven't done so already, please check with the front office, or myself regarding the insurance I accept. If you will be using your insurance to pay for claims and you want me to file for you, you will need to sign the assignment of benefits listed below. We will need to make a copy of your insurance card. It is the patient's responsibility or patient's adult parent or guardian's responsibility to make all copayments at the time that services are rendered. If you have a deductible that must be met you will be required to pay for the services rendered in full until your deductible has been met.

If we are not filing your insurance, you are required to pay for services at the time they are rendered. You will be provided with a receipt containing the necessary information for you to file a claim with your insurance company and the insurance company will reimburse you directly.

Payments are accepted in the form of cash or check. Please make all checks payable to Christy Cushing, L.P.C. For any returned checks, the patient will be charged a $20.00 fee. In the event of default of payment, the costs of collection will be charged to the patient's account.

**It is very important that you realize that regardless of insurance coverage, it is the patient's (or their adult parent/guardian) who is ultimately responsible for payment for services provided. I will do everything possible to accommodate you and meet your insurance requests, but if payment is denied, you will be held responsible for the charges you incurred.

Assignment of Benefits

I authorize release of any treatment or patient information necessary to process insurance claims. I also authorize payment of insurance benefits to be made to Christy Cushing, L.P.C. for services provided at Price Counseling Center.

SIGNED ______________________________ DATE ____________________

Relationship to patient: Self / Parent / Guardian

Appointments and Cancellations

I usually see patients on Monday and Tuesday. My appointments are generally 50 minutes. It is not my policy to "double book" appointments, so my time is exclusively committed to your appointment. When an appointment is missed, my schedule is seriously disrupted as I am unable to make this time available to other clients. For this reason I require that you give me 24 hours notice of your intent to cancel an appointment. **If you cancel an appointment without 24 hours notice**, or if you miss an appointment, **you will be charged for the session**. These charged are not covered by insurance and are due at the next scheduled appointment.

Benefits and Risks of Counseling and Psychotherapy

Persons contemplating counseling or psychotherapy should realize that clients frequently make significant changes in their lives and/or in their relationships. For example, people often modify their emotions, attitudes or behaviors. Partly because of their experiences in counseling and psychotherapy, clients may change employment, begin to feel differently about themselves and to otherwise alter significant aspects of their lives. Although we will do our best to assist you, clients must realize that we cannot promise or guarantee any specific outcome. If you have any questions, we will be happy to discuss them with you in simple, non-technical terms.

Confidentiality

Our relationship with you is confidential in that we will not release information about your status, affiliation with us, condition, etc., without your consent - EXCEPT: we must breach confidentiality in the following instances:

1) As required by Georgia Law (e.g., court subpoena, if you pose a danger to yourself or others or if child abuse is determined or suspected), and/or

2) If you were referred by a physician or other professional (psychologist, counselor, etc.), we will communicate with that professional about pertinent treatment considerations unless you specify otherwise.

3) In the event the services of a collection agency are required, the following information may be released: your name, address, phone number, social security number and balance due.

4) In the case of an emergency cancellation by a therapist, the office secretary (or under unusual circumstances - an associate at Price Counseling Center) may notify you of the cancellation. The person calling will have access only to your name and phone number(s).

5) For the mutual benefit of the client and therapist, please be advised that the associates at Price Counseling Center conduct clinical staffings, during which your case may be discussed. Such group supervision is a common practice in the mental health community and is not intended in any way to breach confidentiality. Only clinical issues are discussed and names of clients are used only in very extenuating circumstances. If you are concerned about the possibility of your case being discussed in clinical staff meetings, please talk to your individual therapist.

6) In the event that you are insured with a managed care company, and want your claims to be covered by your insurance company, it may be necessary to reveal clinical information about you in order for them to process the claim.

Consent to Treatment

I consent to have Christy Cushing, L.P.C. conduct psychological examinations, do psychotherapy, and/or complete related mental health treatments.

My signature below indicates that I have read and understand the information regarding appointments and cancellations, benefits and risks of counseling, confidentiality, consent to treatment and payment policy. Additionally, the information I have provided regarding my history and condition is true and complete to the best of my knowledge. I further understand that you will use this information to develop a treatment plan to help me reach my counseling and psychotherapy goals and this is the sole reason for providing such information.

______________________________ ______________

Client's Signature Date