PRICE COUNSELING CENTER

Emma Price, LMSW

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: _____
Student: Full/Part/NA Ethnicity:_____ 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.

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)

_____

_____

_____

_____

PLEASE READ CAREFULLY AND SIGN THE STATEMENT THAT FOLLOWS

Payment Policy

It is the patient's responsibility or patient's adult parent or guardian's responsibility to make all payments at the time that services are rendered. Upon request, 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 Price Counseling Center, LLC. 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.

Appointments and Cancellations

I see patients on Monday, Tuesday, Wednesday, Thursday, and Friday. 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 charges 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.

Consent to Treatment

I consent to have Emma Price, LMSW 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