ALABAMA PSYCHOLOGICAL SERVICES CENTER, LLC
PATIENT REGISTRATION FORM

FULL NAME OF PATIENT: ________________________________ TODAY'S DATE:__________ THERAPIST: [ ]

ADDRESS:______________________________ CITY:____________________ STATE:______ ZIP__________

HOME PHONE: ______________________________ WORK PHONE: ______________________________

EMAIL: ____

PATIENT'S BIRTH DATE: ______________ AGE: ________ SEX: ________ MARITAL STATUS:__________

PATIENT'S EDUCATIONAL LEVEL: __________ PATIENT'S SOCIAL SECURITY NUMBER : ____________________

PATIENT'S OCCUPATION: ________________ EMPLOYER:________________________________

SPOUSE'S NAME:__________________________ BIRTH DATE:__________ WORK PHONE:______________

IF YOU HAVE OBJECTIONS TO OUR OFFICE MAKING CONTACT WITH YOU AT HOME OR WORK REGARDING APPOINTMENTS, PLEASE NOTE HERE:

PLEASE TELL US WHO REFERRED YOU TO THIS OFFICE:__________________________ PHONE:______________

ADDRESS OF REFERRAL:____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHER'S FULL NAME: ________________________________ SSN____________________

FATHER'S PLACE OF EMPLOYMENT:__________________________ WORK PHONE:______________

MOTHER'S FULL NAME:________________________________ SSN:____________________

MOTHER'S PLACE OF EMPLOYMENT:__________________________ WORK PHONE:______________

IF PATIENT IS A STUDENT, HIS/HER GRADE:____________ SCHOOL:________________________

WHO IS RESPONSIBLE FOR PAYMENT OF SERVICES? ______________________________________

ADDRESS, IF DIFFERENT THAN THAT OF PATIENT: ______________________________________

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: ____

ADDRESS: ____

PHONE NUMBER: __________________ POLICY NUMBER: ________________ GROUP# __________

INSURED'S NAME: ______________________ INSURED'S EMPLOYER: ________________________

INSURED'S DATE OF BIRTH: __________________ INSURED'S SSN: ________________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: ________________________________ **RELATIONSHIP:** ________________________

PHONE #: ________________________________ **WORK #:** ________________________

PAYMENT POLICY

We will file your primary insurance and secondary insurance for you as a courtesy.

- **The patient/responsible party is ultimately responsible for payment of all services.**
- Your insurance is a contract between you and your insurance company. We are not a party to that contract. In the event that your insurance company does not pay within 60 days of the date of service, the account will be forwarded to you for payment.
- Changes in insurance information should be communicated with our office as soon as possible.
- If a service is or may be "non-covered" we will notify you in advance and ask you to sign an "Advance Beneficiary Notice".

Payment for all copays, deductibles, and non-covered services are due at the time services are rendered. We accept Cash, Check, and Credit Cards. There will be a $30 service charge for each returned check.

CANCELLATION POLICY

We require a 24-hour notice by phone or e-mail for cancellation. As a courtesy we will make a reminder call the business day before your appointment. Failure to cancel without 24-hour notice will result in a late cancel or no show fee.

⇨ _____ (Initials) For **Late Cancellations** you will be charged $40.

⇨ _____ (Initials) For **No Shows** you will be charged $75.

Your session is **reserved** for **you** and/or **your** family. A missed session is not reimbursed by insurance and you will be responsible for covering the cost of your counselor's time. After multiple late cancellations or no-shows you may be charged **for the full amount of the session and/or discharged by your therapist.**

NON-COVERED SERVICE POLICY

⇨ _____ (Initials) APSC specializes in providing assessment and therapy for clients. We do not specialize in providing court testimony or becoming involved in custodial agreements. If your therapist is asked to testify or is subpoenaed by an attorney to appear in court you agree to pay a retainer in the amount of $300.00. You also agree to pay for your therapist's time ($150.00-$300.00 per hour), including, but not limited to, preparation of documents, travel, time blocked out of office, and any legal fees incurred by your therapist as part of involvement in legal action.

⇨ _____ (Initials) Your therapist may be asked/required to perform additional services (professional communications, forms, reports, records requests, conferences, etc.) on your behalf. You understand that such services will not be covered by insurance and will be the responsibility of the patient/responsible party. Service charges will range from $30.00-$160.00 depending on level of complexity and time involved.

⇨ _____ (Initials) It is understood that, regardless of amounts reimbursed by your insurance company, you as the patient/responsible party will be responsible for full amounts charged. If your account is turned over to an attorney or collection agency for nonpayment, you will also be responsible for additional attorney or collection fees. If you are covered by managed care you *may* be exempt from payment of charges not fully covered by your insurance.

⇨ _____ (Initials) **I authorize APSC to file insurance for me and to provide the insurance company any information necessary. I further authorize payment to be made directly to APSC.**

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 express authorization of the patient. However, certain communications may be made or certain situations may occur for which confidentiality is limited, and these include:

a) Situations in which a provider believes the patient is a threat to their self or others;
b) Situations in which records are ordered to be released by a Judge of the Courts; or
c) When the communications involve the transmission of contagious or transmittable diseases; or
d) When the communications involve information regarding child abuse or abuse of the elderly; or
e) When the patient's account is turned over to a collection agency or attorney for non-payment.

I hereby acknowledge that I have read, understand and agree to the above **Payment, Cancellation, Non-Covered Service Policies** and **Limitations of Confidentiality**.

______________________________ Patient/Parent/Responsible Party (if minor)

____________________ Date

______________________________ Witness

____________________ Date

SYMPTOM CHECKLIST

ALABAMA PSYCHOLOGICAL SERVICES CENTER, LLC

Comprehensive Psychological and Counseling Services

4800 Whitesport Circle, Suite 2, Huntsville, AL 35801
Phone 256-533-9393 | Fax 256-533-9690
100 Essex Court, Suite A, Madison, AL 35758
Phone 256-325-2388 | Fax 256-325-2395
www.alapsych.com

Patient 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 of 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

ALABAMA PSYCHOLOGICAL SERVICES CENTER, LLC

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CONSENT

To Use and Disclose Your Protected Health Information

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100 Essex Court, Suite A, Madison, AL 35758
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This form is an agreement between the patient, ______________________________________, and Alabama Psychological Services Center, LLC.

When we use the word "you", it can mean you, your child, a relative, or other person. When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions. By signing this form you are agreeing to let us use your information here, and to send it to others if you provide written authorization. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. Copies will be available at that time.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

_____**Receipt of copy of Notice of Privacy Practices acknowledged by client/parent/personal representative**
(Initials)

____ ______________________
Signature of client or his or her personal representative Date

____ ______________________
Printed name of client or personal representative Relationship to the client

____ ______________________
Signature of authorized representative of this office Date

CONSENT

For Behavioral Health Treatment

ALABAMA
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I hereby consent to the behavioral health treatment of _______________________ (patient), by the professional staff of Alabama Psychological Services Center (APSC), LLC. My signature confirms my understanding that this treatment may include assessment, counseling, psychotherapy, and other forms of behavioral health intervention conducted in accordance with commonly accepted practices and standards in the field of mental health.

The outcome of treatment may depend on many variables beyond the control of the treating professional. Therefore, I understand that neither APSC, LLC, nor my treating therapist, can guarantee any specific outcome that will result from my treatment or that of any minor family member. I also understand that any payment for these services, whether made by me or by a third party, is payment made for the APSC, LLC professional's time, experience and effort, and not for any specific outcome.

_________________________________ Client Signature   _______________ Date

_________________________________ Parent/Guardian Signature   _______________ Date

_________________________________ Witness Signature   _______________ Date

CONFIDENTIAL

Authorization for Contacting Patient

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www.alapsych.com

Patient Name: ____ **Date:** ___________________
(Please print)

Should a circumstance arise when it becomes necessary for the office to call you for any reason, (such as to verify or change your appointments), every effort will be made to notify you in a timely manner. Please indicate your preference on how we should contact you.

1. Telephone my home. YES ___ NO ___ If the answer is Yes, and I am unavailable or do not answer the telephone you may:
   - ❑ Leave a message with whoever answers the telephone. YES___ NO___
   - ❑ Leave a message on my answering machine. YES___ NO___
   - ❑ Leave a message on my cell phone. YES___ NO___

2. Telephone my place of employment. YES___ NO___
   If the answer is Yes, and I am unavailable you may leave a message with whoever answers the telephone. YES___ NO___

3. Email Contact
   If you have provided us with your email address, may we use email to contact you or send reminders. Note that under the standards of the Health Insurance Portability and Accountability Act (HIPAA) email may not be secure and might be a risk of exposure of your Protected Health Information (PHI) YES___ NO___

We will attempt to call for a reasonable period. If we are unable to contact you, as you indicated above, do we have permission to write a letter, addressed to you asking that you contact the doctors' office?
YES___ NO___

Signature: _______________________________________ Relationship to Patient: ___________________

Witnessed: _______________________________________ Date: ______________________________

E-MAIL CONSENT

For Non-Secure E-Mail

4800 Whitesport Circle, Suite 2, Huntsville, AL 35801
Phone 256-533-9393 | Fax 256-533-9690
100 Essex Court, Suite A, Madison, AL 35758
Phone 256-325-2388 | Fax 256-325-2395
www.alapsych.com

Patient Name: ____ Date of Birth: ______________________

Patient/Responsible Party E-mail Address: ____

- **Alabama Psychological Services Center, LLC cannot guarantee the security and confidentiality of an e-mail transmission.** Employers and on-line services have the right to access and archive e-mail transmitted through their systems. If your e-mail is a family address, other family members may see your messages, therefore, please be aware that you e-mail at your own risk. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, mis-delivered, or interrupted e-mail. Your provider is not liable for breaches of confidentiality caused by yourself or a third party.

- E-mail is best suited for routine matters and simple questions. You should not send us e-mail for urgent or emergency situations or for matters requiring an immediate response. Your provider will attempt to read and respond promptly to e-mail but cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Time sensitive issues should be taken care of by telephone.

- Please do not use e-mail for communications regarding sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health or substance abuse.

- Please include your full name, birthdate and telephone number in all e-mails. List the subject of your e-mail in the “Subject” line of your message.

- All e-mails between you and your provider regarding diagnosis or treatment will be made a part of your permanent health information.

- Your provider may forward your e-mail to other staff members as necessary for response. However, your e-mail will not be forwarded outside the APSC office staff without your authorization.

- In order to prevent the introduction of computer viruses into our system, do not send attachments to us in your e-mail.

- You are responsible for protecting your password or other means of access to e-mail.

- We can send you an appointment reminder by e-mail. The appointment reminder will include only the date and time of your appointment and your service provider name. We will not encrypt the message. Health care information sent by regular e-mail could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by e-mail, we need you to confirm you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message, by initialing here:______

Signature of Patient/Responsible Party: _____________________________________ Date: ____________

Witness: ____ Date: _____________

CREDIT CARD ON FILE

Automatic Payment Processing Authorization

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For your convenience, we will use this authorization to charge your credit card for any additional amounts incurred as a result of services rendered at Alabama Psychological Services Center. Your information will be kept confidential and only authorized staff will have access to the information. Please note there will be an additional $30 charge for a non-sufficient funds transaction.

By signing below, I authorize Alabama Psychological Services Center (APSC) to charge my credit card for services rendered at APSC to my child or myself without my physical presence at the time of charge. I allow for APSC to charge my credit card for fees not covered by my insurance company to include co-pays, court fees, or other services not covered by my insurance policy. If I wish to pay for services in another manner, I understand that it is my responsibility to notify APSC and make arrangements to pay for services rendered. If at any time I want to change my card information, it is my responsibility to request a new form to update the information. I authorize APSC to continue to charge my credit card for fees associated with services rendered from the first day of services until the close of my case/child's case through APSC's accounting department.

Patient Name (Print):____ Therapist: ____________________

Charge Card Information

Responsible Party (Print): ______________________________________Phone#____________________
First MI Last

Name as it appears on Card, if different from above: ______________________________________
First MI Last

Credit Card #: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Expiration Date: __________ Security Code________

Card Holder's Billing Address: ____
Street Address City State Zip

E-Mail address (for transaction confirmations):______________________________________

______________________________ ____________
Card Holder's Signature Date

______________________________ ____________
Witness Date

INFORMATION
For Clients

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Our Practice

We are a group of licensed mental health professionals in private practice. Our office is open Monday through Thursday from 8:00 AM to 5:00 PM, and Fridays 8:00 – 3:00 p.m. We see clients by appointment only. Appointments are scheduled according to the individual doctors' recommendation. If there is an emergency during office hours, which requires immediate attention, please contact the office by phone.

If an appointment cannot be kept, please contact the receptionist at least 24 hours in advance. There will be a $40 service charge for late cancellations and a $75 service charge for No-Shows.

Confidentiality

Communications between the provider and patient are strictly confidential and protected under Alabama Law and by the ethics of our profession. In order to communicate with others about your case, your provider must have your permission in writing. Our registration form and our Notice of Privacy Practices pamphlet explain the limits of confidentiality.

After Hour Emergencies

Our telephone number is **(256) 533-9393**. If you need to speak with your therapist please make your calls brief. Calls of more than five minutes will be billed at the provider's hourly rate. Calls are answered 24 hours each day, seven days a week. After office hours, you can leave a message on voice mail or in an emergency leave message with answering service to contact your therapist or person on call if he or she is unavailable. If immediate emergency services are required, please call 911.

Fees and Billing

Payment is requested for all services at the time rendered. We accept cash, check, VISA or MasterCard. Charges for sessions vary for each individual provider. Psychological testing varies according to tests administered and an estimate of charges is available upon request. Court ordered services and other forensic activities typically will require an up-front retainer fee. The report fee, records review time, court-related costs, travel or deposition expenses will need to be taken care of prior to distributing reports or results of evaluations to parties involved.

Insurance Claims

As a service to you, we will file your primary insurance and provide you with the necessary information for you to file your own secondary insurance. However, because of the ever-changing complexity of the insurance world, we ask you to investigate and understand your insurance coverage. All co-pays and/or deductibles are due at the time of service. Please understand that there is only so much that the office staff can do in filing your insurance and trying to get payment. It is your responsibility to follow up with your insurance company. You are ultimately responsible for your account balance.

We appreciate the opportunity to serve you and will make every effort to meet your needs.

CHECKING YOUR Mental Health Benefit

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CALLING YOUR INSURANCE COMPANY FOR BENEFITS

The following is a form concerning your outpatient mental health benefits. Since mental health benefits are sometimes different from medical benefits, we advise you to contact your insurance company.

While we do make every effort to verify benefit information prior to your initial appointment, not all information provided by insurance companies is accurate. By contacting your insurance company you will have a better understanding of your benefits and should know what percentage you will be responsible for at each visit with your psychologist or counselor. All insurance companies and policies are different, so please make no assumptions as to what is covered or not covered. *This form is provided for your information, so you will know what questions to ask concerning your coverage.*

On the back of your health insurance card there should be a toll free number for you to call for your mental health/behavioral health benefits. If you don't have a card you should have a benefits manual with the number in it. The following are the questions you should ask the representative when calling:
I am calling to get my outpatient mental health benefits. If your mental health benefits are covered under a managed care ask them the name of the managed care and the phone number for future questions.

Questions to ask your insurance company	YES	NO
Is psychotherapy (90791, 90834 or 90837) by a Licensed Clinical Psychologists (Ph.D.), Licensed Professional Counselor (LPC), or Licensed Clinical Social Worker (LCSW) covered under my plan?		
Is my psychologist/counselor in network? If not, do I have out of benefits?		
Does my policy require a Primary Care Provider (PCP) referral?		
Are there any diagnosis exclusions on my policy		
What is my in/out of network deductible for mental health? ___________ Is this a per calendar year deductible?		
Are there a limited number of visits per calendar year? If yes how many? ___________		
Do I need any pre-authorization for treatment? If yes how many sessions are authorized and is a treatment plan required?		
Is psychological testing by a Licensed Clinical Psychologist (PhD) covered under my policy?		
Does psychological testing require pre authorization? (specific codes to ask about are 96101, 96102, 96118, 96119)		
What is my percentage of coverage?		
What is my co-pay/co-insurance?		
What is my maximum dollar amount per year?		