



Responsive Centers for Psychology and Learning

7501 College Boulevard, Suite 250 ♦ Overland Park, Kansas 66210

Telephone: (913) 451-8550 ♦ Fax: (913) 469-5266

Patient Registration Form - Adult

Today's date:	Clinician:
---------------	------------

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle Initial:	Birth Date: / /	Age:
Street Address:	City:	State:	Zip:	Sex:
Home Phone: <input type="checkbox"/> ()	Cell Phone: <input type="checkbox"/> ()	Work Phone: <input type="checkbox"/> (check preferred contact) ()	Social Security #:	
Marital Status: (circle one) Single / Mar / Div / Sep / Wid	Spouse/Significant Other:	Referred by: <input type="checkbox"/> physician <input type="checkbox"/> relative <input type="checkbox"/> friend <input type="checkbox"/> other Name:		
Employer:	Occupation:	Student: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	School:	

FINANCIALLY RESPONSIBLE PARTY (if different from above)

Last Name:	First Name:	Middle Initial:	Social Security #:	Birth Date: / /
Street Address:	City:	State:	Zip:	Sex:
Home Phone: ()	Cell Phone: ()	Work Phone: ()	Employer:	

FINANCIAL POLICY

All payments will be collected at *check-in* during regular business hours.

Co-pays for patients covered by insurance are due at the time services are rendered. Anytime our receptionist is unavailable, please place your payment in the lockbox to the left of the receiving window in the waiting area, or pay your clinician immediately following your appointment.

For patients who are not using insurance or are using an insurance plan with which their clinician is not contracted, payment in full is due at the time of service. Upon request, we will provide you with a Visit Summary form to file with your insurance company for reimbursement.

If your insurance company requires prior authorization and you have not obtained it, the cost of that visit will be your responsibility.

Your clinician reserves the right to charge you if you fail to notify the office of a cancellation 24 hours prior to your scheduled appointment.

I have read and understand the above stated policies.

Signature

Date

EMERGENCY INFORMATION

Last name:	First:	Relationship to patient:
Home Phone: ()	Cell Phone: ()	Work Phone: ()



Responsive Centers for Psychology and Learning

Assignment of Benefits Form – Adult

Patient's Name:		Clinician:			
PRIMARY INSURANCE INFORMATION					
Primary Policy holder is: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> other					
Please complete the following if the primary policy holder is someone other than yourself:					
Primary Policy Holder Last Name:		First Name:	Middle Initial:	Birth Date: / /	
Social Security #:					
Street Address:		City:		State:	Zip:
Home Phone: ()	Work Phone: ()	Cell Phone: ()	Relationship to patient:		
Please complete the following only if you are unable to supply a copy of your card:					
Primary Insurance Company Name:		ID #:	Group #:	Phone #: ()	
Street Address:		City:		State:	Zip:
SECONDARY INSURANCE INFORMATION (if applicable)					
Secondary Policy holder is: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> other					
Please complete the following if the secondary policy holder is someone other than yourself:					
Secondary Policy Holder Last Name:		First Name:	Middle Initial:	Birth Date: / /	
Social Security #:					
Street Address:		City:		State:	Zip:
Home Phone: ()	Work Phone: ()	Cell Phone: ()	Relationship to patient:		
Please complete the following only if you are unable to supply a copy of your card:					
Secondary Insurance Company Name:		ID #:	Group #:	Phone #: ()	
Street Address:		City:		State:	Zip:
AUTHORIZATION OF PAYMENT					
Please choose ONE of the following:					
<input type="checkbox"/> I am a private payment patient. I will be responsible for payment in full at the time each service is rendered.					
Signature: _____		Date: _____			
<input type="checkbox"/> I authorize payment of insurance benefits to Responsive Centers for Psychology and Learning, 7501 College Boulevard, Suite 250, Overland Park, KS 66210 for services rendered. I further authorize the release to my insurance company of any medical or other information necessary to process my insurance claims. I understand that I am responsible for all balances unpaid by my insurance company including, but not limited to, deductibles and co-pays.					
Signature: _____		Date: _____			



Responsive Centers for Psychology and Learning

REPORT TO PRIMARY CARE PHYSICIAN

I authorize **Responsive Centers** to exchange information with my primary care physician. _____

Patient Signature

Please provide the following information so that we are able to contact your physician. A phone book is available at the front desk for your convenience.

Patient Name:	Patient DOB:
Patient Social Security Number:	Authorization # (if applicable):
Physician Name:	Physician Phone #:
Physician Address:	Physician Fax #:

I DO NOT authorize **Responsive Centers** to exchange information with my primary care physician. _____

Patient Signature

FOR OFFICE USE ONLY

This is a(n) Initial Summary Interim summary Termination Summary

Suggested Diagnoses

Axis I: _____

Axis II: _____

Psychotropic Medications

Current psychotropic medications: _____

Please evaluate this patient for the appropriateness of medication for the treatment of: _____

Treatment Goals

Treatment Modalities Individual therapy Family therapy Group therapy Couples therapy

Psychotropic medication Referral to community resources _____

Psychologist/Clinician Signature

Date

Please complete and return if medication is prescribed or changed or if there are any medical conditions or medications that may be causing or contributing to the patient's symptoms of mental disorder.

Medication prescribed: _____ Dose: _____

Medication prescribed: _____ Dose: _____

Physician Signature

Date



Responsive Centers for Psychology and Learning

BIOGRAPHICAL INFORMATION

This information is to help your clinician or educator prepare for your visit and to facilitate planning your treatment.

Name: _____ Nick Name: _____ DOB: _____ Age: _____

PRESENTING PROBLEMS

What concerns or problems, including symptoms, convinced you to seek help now?

How long has this been a problem? _____ Have you been treated for this problem before? _____

If yes, who treated you? _____

These problems are: mildly upsetting moderately severe very severe totally incapacitating

FAMILY INFORMATION

Spouse /Significant Other: _____

Children (names & ages): _____

EDUCATION

Highest degree earned: _____ School: _____

JOB HISTORY

Current occupation: _____ Years on the job: _____

Previous occupation: _____ Years on the job: _____

MEDICAL HISTORY

Primary Care Physician: _____ Date of last physical exam: _____

Medical problems you are being treated for currently:

Allergies: _____

Current medications: _____

PSYCHIATRIC HISTORY

Previous mental health treatment: _____

Level of care: Inpatient Partial hospital Outpatient

Reason for treatment: _____

Treating clinician(s)' name(s) _____



Responsive Centers for Psychology and Learning

BIOGRAPHICAL INFORMATION CONT'D

Have you ever attempted suicide? yes no If yes, when _____

Are you currently having suicidal ideation? yes no Do you have a plan? yes no

Please describe any family history of psychiatric problems:

ALCOHOL/DRUG USE/ABUSE

Abstain Social Episodic abuse Loss of control Use in spite of adverse consequences

Recovering

Types of substance(s): _____

Frequency: _____ Amount: _____

Family member(s) abuse: yes no

If yes, who: _____

LEGAL HISTORY

Have you ever been arrested? yes no

If yes, for what reason and age: _____

SOCIAL HISTORY

With whom do you discuss difficult problems? Family Friends Others _____

Do you have a social support group? yes no

What do you do for pleasure and relaxation? _____

PATIENT RIGHTS AND RESPONSIBILITIES

Patients have the right to:

- Be treated with professionalism and respect
- Confidentiality (see Notice of Privacy Rights)
- Receive explanations about office procedures, or answers to any questions you may have
- Participate in decisions regarding your treatment plan
- Consent to or refuse any treatment

Patients have the responsibility to:

- Provide information needed by the professional staff to care for you
- Keep all scheduled appointments and be on time
- Cancel at least 24 hours in advance if you are unable to keep an appointment
- Pay your fees, deductibles, and co-payments
- Provide insurance information if you wish to use your insurance benefits



Responsive Centers for Psychology and Learning

CONSENT FOR TREATMENT

Welcome to our practice. Please read this document carefully and note any questions you might have so you and your clinician can discuss them. **Once you sign this, it will constitute a binding agreement between us.**

NOTICE OF PRIVACY PRACTICES

By signing this agreement you consent to the use of your personal health information for purposes of treatment, payment or healthcare according to the **Notice of Privacy Practices** posted on the Responsive Centers website and provided at the Responsive Centers office.

PSYCHOTHERAPY

Psychotherapy varies depending on the personality of both the clinician and the patient and the particular issues that the patient wants to address. There are a number of different approaches that can be used. Outpatient psychotherapy is voluntary and requires an active effort on your part. In order to be most successful, you will have to work both during sessions and at home.

Psychotherapy has both benefits and risks. Psychotherapy often leads to significant reduction of feelings of distress, better relationships, and resolutions to specific problems. Risks sometimes include experiencing uncomfortable levels of feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Psychotherapy sometimes requires recalling unpleasant aspects of your history. It is important that you discuss these issues in an honest and forthright manner. There are no guarantees about results.

By the end of the first few sessions, your clinician will be able to offer you some initial impressions of what your work will include and an initial treatment plan. You should evaluate this information along with your own assessment about whether you feel comfortable continuing. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the clinician you select.

SESSIONS

If psychotherapy is initiated, 45-50 minute meetings will be scheduled at mutually agreed upon times. **Once an appointment is scheduled, you will be expected to pay for it unless you provide 24-hours advance notice of cancellation (unless you and your clinician agree you were unable to attend due to circumstances beyond your control).** Generally, missed appointments are not insurance reimbursable and must be paid for by the patient.

Your clinician will be happy to discuss session fees with you. You are expected to pay all co-pays at the time of each session. In addition to your appointments, we charge on a prorated basis for other professional services that are not insurance reimbursable such as report writing, telephone conversations that last longer than 10 minutes, attendance at meetings or consultations with other professionals that you have authorized or requested, preparation of records or treatment summaries, and/or the time required to perform any other services which you may request of your clinician

CONFIDENTIALITY

In general, the confidentiality of all communications between you and your clinician is protected by law. Clinicians can release information only with written permission with some exceptions. In most judicial proceedings, you have the right to prevent your clinician from providing information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require testimony.

There are some situations in which your clinician is legally required to take action to protect others from harm, even though that requires revealing some information about a your treatment. If your clinician believes that a child, an elderly person, or a disabled person is being abused, your clinician is required to file a report with the appropriate state agency.

If your clinician believes that you are a serious threat to another person, your clinician is required to take protective actions, which may include notifying the potential victim, notifying the police, and seeking appropriate hospitalization. If you threaten to harm yourself, your clinician may be required to seek hospitalization or contact a family member or others who can provide protection.

INDEPENDENT PRACTICE

Responsive Centers for Psychology and Learning is an association of independently practicing professionals, which shares certain expenses and administrative functions. While members share a name and office space, they are completely independent in providing you with clinical services and are fully responsible for those services. Any matters concerning your clinical care should be addressed with clinician first. If the matter is not resolved to your satisfaction, you may contact our executive director.

Please note that your clinician is not authorized to practice medicine or prescribe medication but will work closely with your physician to ascertain any medical or biological origins that may impact your symptoms.

I have read the above information and understand its contents. I give my full consent for treatment. I have had the opportunity to read and obtain a copy of the Notice of Privacy Practices.

Print name

Witness



Responsive Centers for Psychology and Learning

Signature

Date