Doctor or therapist: Marvi Haynes, LPC, LMFT **CHILD/ADOLESCENT**

# REGISTRATION INFORMATION

*Please Print*

**CONFIDENTIAL**

Child: _____ Birth date: _____ Gender: M F

Your Name: _____ Relationship: _____ Today's Date: _____

Address: _____ City: _____ ST: _____ Zip: _____

Child's Grade: _____ School: _____ SSN: _____

Child lives with: ___ Both parents/1 home ___ Both parents/2 homes ___ 1 parent (specify): _____
___ Other relative: _____ ___ Other arrangement: _____

Do you have the legal right to seek mental health treatment for this child? ___ Yes___No
If NOT, do you have permission to seek such treatment? ___ Yes___No

**CONTACT PREFERENCES**

Phone (H): _____ (W): _____ (C): _____

| | | |
|---|---|---|
| ___OK to leave message | ___ OK to leave message | ___ OK to leave message |
| ___ with details | ___ with details | ___ with details |
| ___ call back # only | ___ call back # only | ___ call back # only |
| ___ NO message | ___ NO message | ___ NO message |

Email: _____(confidentiality cannot be guaranteed for email communication)

Written Communication/Mail:
___ OK to mail to home address ___ OK to mail to work address: _____

Signature: _____ Date: _____

**PRIMARY CARE PHYSICIAN** Name: _____ Phone: _____

Address: _____ City: _____ ST: _____ Zip: _____

**May we contact your PCP if we have a release of information from you to do so? _____ YES _____ NO**

**EMERGENCY INFORMATION** In case of emergency, please notify: _____

Phone: _____ Relationship to child: _____

**ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES** I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date Name of Personal Representative/Description of Authority

**NOTIFICATON OF CHANGES** I understand I am responsible for notifying the office of any change of address, phone number and/or insurance.

_____ _____

Signature of Patient or Personal Representative Date

Client Name: _____

**Client Information (cont'd)**

PAST AND PRESENT HISTORY

Put an (X) in the box which includes health/illness/condition history for you and your family.

| | Good Health | Poor Health | Deceased | Depression | Suicide | Alcohol Abuse | Drug Abuse | Inattention | Psychosis | Severe Anxiety | Panic Attacks | Nervous Breakdown | Hospitalization for Mental Illness | Eating Disorder | Bipolar Disorder | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient | | | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | | | |
| Mother | | | | | | | | | | | | | | | | |
| Brothers | | | | | | | | | | | | | | | | |
| Sisters | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Mother's Mother | | | | | | | | | | | | | | | | |
| Mother's Father | | | | | | | | | | | | | | | | |
| Father's Mother | | | | | | | | | | | | | | | | |
| Father's Father | | | | | | | | | | | | | | | | |

Client Name: _____

**Registration Information (cont'd)**

Medical Information:

Brief Medical History:

| | | | |
|---|---|---|---|
| _____ Seizure Disorders | _____ HIV | _____ Migraines | _____ Developmental Delay |
| _____ Diabetes | _____ High BP | _____ M.S./M.D. | _____ Head Injury |
| _____ Heart Condition | _____ TB | _____ Polio | _____ Birth Trauma |

_____ Other _____

_____

| Current Medications and Dosage | Prescribing Doctor | Reason(s) for their use: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Other persons living in the home:

| Name | Relationship | How Long? |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

It there is any other information you would like us to know at this time, please continue on the reverse side and check here _____. Thank you for completing the registration information.

**NOTICE OF PRIVACY PRACTICES**
**(The following is a summary. The full text is located in our waiting room.)**

We at Austin Psychotherapy Associates are committed to maintaining the confidentiality of your medical information. In most cases, your records will not be released without your written consent (which you can revoke). However, there are a few exceptions. We are permitted to disclose your medical information to other professionals involved in your treatment.

- We are permitted to use and disclose your medical information to your insurance company, if you choose to use them, or as required by worker's compensation law.
- We may disclose your medical information for public health concerns as mandated by federal or state government.
- We are required to report child abuse or neglect.
- We may release information if you are under the custody of law enforcement, or if ordered by the court.

You may request in writing that we restrict how your information is disclosed for treatment, payment or healthcare operations. Although we are not required to restrict this information, we will do so except in emergency situations.

It is our policy not to release information to family members or other individuals without your written consent. You have a right to access your health records with some limitations. (See restrictions in the full text.) You must submit your request in writing to the Privacy Officer.

**Complaints**
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or with the government. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

**Our Promise to You**
We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

**Questions and Contact Person for Requests**
If you have any questions or want to make a request pursuant to the rights described above, please contact Gayle Harkrider, Privacy Officer, at:

4601 Spicewood Springs Rd
Building 4, Suite 200
Austin, TX 78759

**PATIENT COPY**

This notice is effective November 14, 2006.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

**MARVI HAYNES, LPC, LMFT**
**STATEMENT OF UNDERSTANDING**
**CLIENT WHO IS A MINOR**

**Consent for Treatment of a minor:**
For any client below the age of 18, I certify that I have legal responsibility for this child _____ DOB: _____ and give full consent for the completion of an evaluation and the provision of treatment as necessary until otherwise notified. If applicable, I will provide legal documentation of guardianship and/or legal right to seek mental health intervention for this child.

**Confidentiality:**
You have the right to confidentiality in your therapy. Information concerning your therapy will not be disclosed without your prior written permission except for the following legal exceptions:
1.Life or safety of you or someone else is seriously threatened.
2.There is good reason to believe that you are abusing or neglecting a child or vulnerable adult or if you give me information about someone else who is doing this, child/adult protective services and/or the appropriate law enforcement agency must be notified.
3.Court ordered.
4.An insurance benefit is filed and the claims payer requires information, i.e. diagnosis, types of treatment, dates, etc.
5.Parents or legal guardians of minors are legally privy to information disclosed during treatment. The therapist will discuss and clarify issues of privileged information regarding the child's treatment.

**Emergencies/Telephone Counseling:**
Psychiatric emergencies should be directed to 911 if life or safety is threatened. The office phone number (512) 231-0164, is answered by staff during business hours and by a recording after hours. After hours, the answering service will direct your call to me or the person covering for me. The answering service phone number is (512) 404-9098 and is on our office recording.

**Scheduling of appointments:**
Please conscientiously keep all scheduled appointments. If it is necessary to cancel an appointment, please give at least 24 hours notice. Monday appointments must be canceled before noon on the preceding Friday. **You will be charged a fee for missed appointments or appointments canceled without 24 hours advanced notice (see fee schedule).** Insurance companies do not pay for missed appointments.

**Fee policy:**
Any returned checks are subject to a $25 charge. Should your account be referred for collection, you agree to pay 6% interest plus a $25 collection fee and reasonable attorney fees and/or court costs.

**Fees for services:**
Individual psychotherapy (50 min) = $120.00
Individual psychotherapy (80 min) = $160.00
Marital/Family psychotherapy (50 min) = $140.00
Deposition/Testimony/Legal Work billed = $400.00/hour
(includes testimony, consultation, depositions, and reports)
*Fees for other services provided upon request*

Missed appointment = **full fee**
Telephone consultation = $25.00/15min.
Emergency calls = $25.00/15min.
Written reports = $100.00/hour
Telephone consultation w/ attorney = $35.00/15 min.

**I work with a group of independent mental health professionals, under the name of Austin Psychotherapy Associates. 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, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.**

**I UNDERSTAND AND AGREE TO THE ABOVE TERMS.**

_____ _____
Client Name Printed Guardian name printed

_____ _____
Guardian Signature Date

Revised: 4/2015

PATIENT COPY

**MARVI HAYNES, LPC, LMFT**
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PATIENT COPY

_____ _____
Client Name Printed Guardian name printed

_____ _____
Guardian Signature Date

Revised: 4/2015

**Marvi Haynes, LPC, LMFT**
4601 Spicewood Springs Road
Building 4, Suite 200
Austin, Texas 78759
Office: (512)231-0164
Fax: (512)276-8958

# Credit Card Authorization Form

*Date:* _____

RE: Client _____

I am providing the following credit card information to Ms. Marvi Haynes to keep on file in the event that I do not keep an appointment, or I cancel an appointment without 24 business hours' notice (with full details of relevant office policies provided to me already on separate forms).

I authorize Ms. Haynes to charge my credit card account the full specified amount for the missed appointment.

Select one: VISA MASTERCARD

Card number: _____ 3 or 4 digit code: _____

Expiration date: _____

Name on card: _____

Credit card billing address: _____

City_____ State_____ Zip code: _____

Cardholder's phone number: (_____)_____
Area Code

Signature: _____

**CONFIDENTIAL**
Revised: 4/2015