

**REGISTRATION INFORMATION**

*Please Print*

**CONFIDENTIAL**

Client Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Gender: F M SSN: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Relationship Status: Single Married Domestic Partner Divorced Widowed Separated Other:

Your employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Spouse/Partner Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Spouse/Partner Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**CONTACT PREFERENCES**

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

OK to leave message

with details

call back # only

NO message

OK to leave message

with details

call back # only

NO message

OK to leave message

with details

call back # only

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: \_\_\_\_\_

**EMERGENCY INFORMATION** In case of emergency, please notify: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**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 or phone number.

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Signature of Patient or Personal Representative

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Date



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 _____			

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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 health care 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:

**PATIENT COPY**

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

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.

**LEANN ARTIS, LMFT, LPC  
STATEMENT OF UNDERSTANDING**

**Consent for Care:**

I give full consent for the completion of an evaluation and the provision of treatment as necessary, by the above named therapist, until otherwise notified. I understand that no promises have been made to me as to the result of treatment or procedures provided by this therapist. If I have any questions about the following information or about anything related to my therapy, I will discuss this with the therapist.

**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 treatment.
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:**

Medical and/or 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, you must 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).**

**Fee policy:**

Any returned checks are subject to a \$30 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:**

- |  |   |
|--|---|
| - Initial Consultation (50 min.) = \$120   | - <b>Missed appointment = full fee</b>  |
| - Individual psychotherapy (50 min.) = \$120   | - Telephone consultation = \$30/15min.  |
| - Marital/ Family psychotherapy = \$120 (60 min.)<br>\$180 (90 min.)                                       | - Release of records = \$25 to \$50   |
| - Parenting Coordination/ Facilitation (90 min.) = \$180 (\$90/parent)                                     | - Review of records = \$40/15min.   |
| - SAPCR Consultation (90 min.) = \$180   | - Deposition/Court Appearance = \$200<br><b>(door to door, paid in advance, 48 hour notice)</b> |
| - Guardian ad Litem (90 min.) = \$180  | - Telephone consultation w/ attorney = \$30/15min.  |
| - Court Appearance due to subpoena = \$200/ hour<br><b>(door to door, paid in advance, 48 hour notice)</b> |   |
| - Home/Site Visit \$120.00 door to door  |   |

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 Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

**CONFIDENTIAL**

Revised: 8/2014

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\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

**CONFIDENTIAL**

Revised: 8/2014