REGISTRATION INFORMATION

Please Print

CONFIDENTIAL

Name: _____ Today's Date: _____

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

Birthdate: _____ Gender: F M SSN: _____

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 ___ 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: _____

EMERGENCY INFORMATION In case of emergency, please notify: _____

Phone: _____ Relationship: _____

AUTHORIZATION AND RELEASE I hereby authorize the clinician to release all information necessary to secure payment of benefits from my insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I fully understand that I am financially responsible for all charges whether or not paid by my insurance company.

_____ _____

Signature of Patient or Personal Representative Date

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																
Spouse																
Children																
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.

CONFIDENTIAL

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.

CONFIDENTIAL