Clinician: Linda Eldredge, Ed.D. **CHILD/ADOLESCENT**

## REGISTRATION INFORMATION

*Please Print*

# CONFIDENTIAL

Child: _____ Birthdate: _____ Gender: M F

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

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

Child's Grade: _____ School: _____

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: _____

**EMERGENCY INFORMATION** In case of emergency, please notify: _____
Phone: _____ Relationship to child: _____

**INSURANCE FILING** Would you like us to file your insurance for you? Yes No

**AUTHORIZATION AND RELEASE** I hereby authorize Dr. Eldredge 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 Insured/Guardian 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 | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| 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 or Employee Assistance Program (EAP), 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 abuse or neglect of children and people who are elderly or disabled.
- 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**

**Confidential**

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.

**Linda Eldredge, Ed.D**
**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 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 9-1-1 if life or safety is threatened. Our office phone number (512) 231-0164, is answered by staff during business hours and by a recording after hours. **Emergency calls and telephone counseling are not covered by insurance, so these charges are your full responsibility.** After hours, the answering service will direct your call to Dr. Eldredge or the clinician covering for her. The after-hours 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 business 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 business hours advance notice (see fee schedule). Insurance companies do not pay for missed appointments.** Exceptions to this policy may be made for unforeseen emergencies but must be discussed on a per case basis with the therapist. **If you miss an appointment and do not contact the office about the reason that day, you will be charged a fee.**

**Fee policy:**

While the filing of insurance claims is a courtesy that is extended to you, all charges are ultimately your responsibility for the date of service. **All copayments, unmet deductible expenses, and services or charges not covered by insurance are DUE IN FULL AT THE TIME OF SERVICE.** Any returned checks are subject to a $40 charge. Those with out-of-network benefits must pay the full fee upfront and have the insurance company reimburse them. **Patient balances past due more than 90 days will have 5% interest compounded monthly plus all necessary collection fees and applicable attorney fees and/or court costs unless payment arrangements have been made and honored.**

**Fees for services:**

Initial diagnostic evaluation (45 min.) = $180
Individual psychotherapy (45 min.) = $150
Family psychotherapy (45 min.) = $150
Records Request=$30
Consultation and training = fee by contract
Legal consult = $300/hr., rounded to the nearest 15 min.

**Missed appointment = full fee**
Professional Letter/Forms $150/hr., rounded to the nearest 15 min.
Telephone consultation $150/hr., rounded to the nearest 15 min.

**Dr. Eldredge offices with several 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, Dr. Eldredge is completely independent in providing you with clinical services and she alone is fully responsible for those services. Her 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.**

**CONFIDENTIAL**

_____ _____
Client Name Printed Guardian Name Printed

_____ _____
Guardian Signature Date

Revised 2-2017

**Linda Eldredge, Ed.D**
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**I UNDERSTAND AND AGREE TO THE ABOVE TERMS.**

_____ _____

Client Name Printed Guardian Name Printed

_____ _____

Guardian Signature Date

**CONFIDENTIAL**
**PATIENT COPY**

Revised 2-2017

**Linda Eldredge, Ed.D., Psychologist**
**4601 Spicewood Springs, # 4-200, Austin, TX 78759**
**512.231.0164 (FAX) 512.276-8958**
www.austinpsych.com

# FEE POLICY

| | |
|---|---|
| Initial Session, 45 minutes: | $180.00 |
| Individual, Couples, or Family Therapy, 45 minutes: | $150.00 |
| Missed Appointments and Late Cancellations (Full Fee): | $150.00 |
| Phone Counseling, Rounded to the Nearest 15 minutes: | $150.00 |
| Consultations and Written Reports, Rounded to the Nearest 15 minutes: | $150.00 |
| Court or Legal-Related Consultations, Rounded to the Nearest 15 Minutes: | $300.00 |

These fees may or may not directly impact you, depending on the type and amount of mental health insurance or agency benefits that you have. If you have any questions related to your mental health benefits, please inform our office, and my billing service will contact you.

**All copayments, unmet deductible expenses, and services or charges not covered by insurance are DUE IN FULL AT THE TIME OF SERVICE.** Any returned checks are subject to a $40 charge. If you have out-of-network benefits, you must pay the full fee upfront and have the insurance company reimburse you. **Patient balances past due more than 90 days will have 5% interest compounded monthly plus all necessary collection fees and applicable attorney fees and/or court costs unless payment arrangements have been made in writing and honored.** All charges are ultimately your responsibility for the date of service.

**Please note that insurance does not pay for missed appointments, late cancellations (less than 24 business hours' notice) phone counseling, consultations, or written reports, so these charges are your full responsibility.**

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

_____

Printed Name Signature Date

**Linda Eldredge, Ed.D., Psychologist**

## CREDIT CARD PROCEDURES

I do not accept the following or similar types of credit cards:

- Signature Visa
- Signature Preferred and/or Corporate Visa
- WorldCard MasterCard
- WorldCard World MasterCard
- Rewards MasterCard
- Business MasterCard
- Rewards Visa
- Business Visa
- Discover
- American Express
- Any other type of Rewards or Points card

The typical basic credit card, whether Visa or MasterCard, charges Dr. Eldredge approximately $5 to process a charge, after all of their percentages, numerous fees, taxes, etc., are added together. However, most of the above types of cards charge an additional $5 - $12 per transaction. For some of you, this means your entire copay goes to credit card companies.

"Merchants" are charged an amount to pay for the rewards or points your credit company "gives" you. Merchants are charged from two to five times more for those rewards or points than they actually give you, meaning the above fees go straight to the credit card company profits. Large businesses and companies may be able to absorb the costs outlined above, but as a self-employed sole proprietor, I cannot.

Your Options:

_____ I will use cash or checks for all future charges.

_____ I will use another type of credit card and provide that card information.

_____ I continue to use one of the above type cards and agree to pay an additional 5% per transaction.

Printed Name Signature Date

Revised February 2017

# CREDIT CARD INFORMATION

Please provide the required information about the credit card you will use to pay any fees for missed appointments or to make payments to your account.

Type of Credit Card: Visa_____ MasterCard_____

Credit Card Number: _____

3-Digit Security Code on the Back of the Card: _____ Expiration Date: _____

Name as Printed on the Card: _____

Billing Address for Credit Card: _____

_____

By my signature below, I grant Linda Eldredge, Ed.D., my permission to charge the account described above for missed appointments or late cancellation fees.

Printed Name Signature Date

**Optional – Line through if you do <u>not</u> wish to grant this permission.**

By my signature below, I grant Linda Eldredge, Ed.D., my permission to charge the account described above for insurance copays of scheduled sessions.

Printed Name Signature Date

**Optional – Line through if you do <u>not</u> wish to grant this permission.**

By my signature below, I grant Linda Eldredge, Ed.D., my permission to charge the account described above for any outstanding balance on a monthly basis.

Printed Name Signature Date

**PAYMENTS DUE:** Your payment or copayment is due at the time of service. Any amounts not paid by your insurance (such as annual deductibles) are your responsibility to pay.

**CANCELLED APPOINTMENTS:** A **FULL 24 BUSINESS HOURS' NOTICE** is required, or your credit card will be billed for the **FULL AMOUNT** of your missed appointment. Insurance does not pay for missed appointments or late cancellations.

Revised February 2017

Linda Eldredge, Ed.D. Office Use: Provisional Dx: _____

**Insurance Form must be complete.**

## Patient Information

Representative Name: _____ Marital Status: _____
Current Address: _____ Gender: ____ Date of Birth: _____
City, State, Zip: _____ Social Security Number: _____
Phone (Home/Cell): _____ Phone (Work): _____
Employer's Name: _____ Email Address: _____
Employer's Address: _____ Occupation: _____
Family Physician: _____ Referred By: _____
In Case of Emergency, Notify: _____
(Area Code & Phone #): _____ (Relationship): _____

## Insurance Information

**If you are using insurance, we need a copy of your insurance card.**

**YES or No _____** I authorize the release of any clinical or other information necessary to process my insurance claim.
**YES or No _____** I authorize payment of insurance benefits to Dr. Eldredge.
**YES or No _____** Do you have secondary insurance besides the listed insurance below? List on a separate sheet of paper.

Policy Holder's Name: _____ Policy Holder's S.S.#: _____
Policy Holder's ID #: _____ Policy Holder's Group #: _____
Effective Date of Coverage: _____ Employer: _____
Policy Holder's Date of Birth: _____ Employer's Phone Number: _____
Policy Holder's Address and Phone Number If Different Than Above: _____
_____
Insurance Company Claim Phone Number:
Policy Holder's Gender: _____ Policy Holder's Marital Status: _____
_____
Insured's Signature Relationship to Patient Date

Insurance Company's Billing Address: _____
**REQUIRED:** _____
Could Be a Third Party _____

## ALL QUESTIONS MUST BE FILLED IN COMPLETELY

4601 Spicewood Springs Rd., Bldg. 4, Ste. 200, Austin, TX 78759 512-231-0164 (FAX) 512-276-8958