

REGISTRATION INFORMATION

Please Print

CONFIDENTIAL

Child: Birthdate: 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 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 to child:

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 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

NOTIFICATION 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: \_\_\_\_\_

**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 Doseage	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.

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