NORTH STAR
Counseling Services

PATIENT REGISTRATION FORM

FULL NAME OF PATIENT: _____ TODAY'S DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

PATIENT'S BIRTH DATE: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

PATIENT'S EDUCATIONAL LEVEL: _____ PATIENT'S SOCIAL SECURITY #: _____

PATIENT'S OCCUPATION: _____ EMPLOYER: _____

SPOUSE'S NAME: _____ BIRTH DATE: _____ WORK PHONE: _____

IF YOU HAVE OBJECTIONS TO OUR OFFICE MAKING CONTACT WITH YOU AT HOME, WORK OR ON YOUR CELL REGARDING APPOINTMENTS, PLEASE NOTE HERE: _____

PLEASE TELL US WHO REFERRED YOU TO THIS OFFICE: _____ PHONE: _____

ADDRESS OF REFERRAL: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHER'S FULL NAME: _____ SSN: _____

FATHER'S PLACE OF EMPLOYMENT: _____ WORK PHONE: _____

MOTHER'S FULL NAME: _____ SSN: _____

MOTHER'S PLACE OF EMPLOYMENT: _____ WORK PHONE: _____

IF PATIENT IS A STUDENT, HIS/HER GRADE: _____ SCHOOL: _____

WHO IS RESPONSIBLE FOR PAYMENT OF SERVICES? _____

ADRESS, IF DIFFERENT THAN THAT OF PATIENT: _____

INSURANCE INFORMATION:

PRIMARY INSRANCE COMPANY: _____

ADDRESS: _____

PHONE #: _____ POLICY #: _____ GROUP #: _____

INSURED'S NAME: _____ INSURED'S EMPLOYER: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SSN #: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: _____ RELATIOSHIP: _____

PHONE #: _____ WORK #: _____

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PAYMENT POLICY

Copayments, deductibles, and non-covered services are due at the time services are rendered. We accept Cash, Check, Visa, Discover, MasterCard and American Express. There will be a $30 service charge for each returned check.

We require a 24 Hour notice for cancellation. We make a courtesy reminder call the business day before your appointment. The absence of a confirmation of your appointment does not release you of a duty to cancel the appointment via telephone or e-mail.

_____ For **Late Cancellations** you will be charged **$30.**
(Initials)

_____ For **No Shows** you will be charged **$30.**

Your session is **reserved for you** and/or your family. A missed session is not reimbursed by insurance and you will be responsible for covering the cost of your counselor's time. After multiple late cancellations or No-Shows you may be **charged for the full amount of the session and/or discharged by your therapist.**

We will file your primary insurance for you as a courtesy.

- **The patient/responsible party is ultimately responsible for payment of all services.**
- Your insurance is a contract between you and your insurance company. We are not a party to that contract. In the event that your insurance company does not pay within 60 days of the date of service, the account will be forwarded to you for payment.
- Changes in insurance information should be communicated with our office as soon as possible.
- If a service is or may be "non-covered" we will notify you in advance and ask you to sign an "Advance Beneficiary Notice."

_____ It is understood that, regardless of amounts reimbursed by your insurance company, you as the patient/responsible party will be responsible for full amounts charged. If your account is turned over to an attorney or collection agency for nonpayment, you will also be responsible for additional attorney or collection fees. If you are covered by managed care you may be exempt from payment of charges not fully covered by your insurance.

_____ **I authorize NSCS to file insurance for me and to provide the insurance company any information necessary. I further authorize payment to be made directly to NSCS.**

LIMITATIONS ON CONFIDENTIAL NATURE OF COMMUNICATIONS

Communications between a licensed psychologist, psychiatrist, or a licensed professional counselor and the patient are confidential and will not be released without the express authorization of the patient. However, certain communications may be made or certain situations may occur for which confidentiality is limited, and these include:

1. Situations in which a provider believes the patient is a threat to him/herself or others;
2. Situations in which records are ordered to be released by a Judge of the Courts, or
3. When the communications involve the transmission of contagious or transmittable diseases; or
4. When the communications involve information regarding child abuse or abuse of the elderly; or
5. When the patient's account is turned over to a collection agency or attorney for non-payment.

I hereby acknowledge that I have read, understand, and agree to the above **Payment Policy** and **Limitations of Confidentiality.**

_____ _____
Patient/Parent/Responsible Party (if minor) Date

_____ _____
Witness Date

Thank you for taking the time to complete this form!