



Registration Form

Procedure Code:

Diagnosis Code:

Date:

Client Name: _____ DOB: _____

Address: _____
Street City State Zip Code

Phone: _____
Home Cell Work

Email: _____

Guardian: _____
if minor Guardian Name Relationship Phone

Can we leave a message?

- Yes
 No

Gender:

- Male
 Female
 Transgender
 Non-Binary
 Prefer not to answer

Preferred Pronouns:

- He/Him
 She/Her
 They/Them

Marital Status: Single Married Divorced Widowed Separated

Emergency

Contact: _____
Contact Name Relationship Phone

Assignment & Release

I understand and verify that I (or my dependent) have insurance coverage with and sign directly to Mindful Balance Psychological Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Client/Guardian Signature

Relationship

Date

INSURANCE INFORMATION

PRIMARY INSURANCE

SELF PAY PRO BONO

Insurance Name: _____ Contract #/ID: _____

Subscriber's Name: _____ Group #: _____

Subscriber's DOB: _____ Relationship: _____

Subscriber's Employer: _____

SECONDARY INSURANCE

Insurance Name: _____ Contract#/ID: _____

Subscriber's Name: _____ Group#: _____

Subscriber's DOB: _____ Relationship: _____

Subscriber's Employer: _____

WORKMEN'S COMP / AUTO INSURANCE ONLY

Client Name: _____ Client DOB: _____

Client Address: _____

Social Security #: _____ Claim #: _____

Name of Adjuster: _____ Adjuster's Phone #: _____

Date of Injury: _____ Name of Employer: _____
(at time of injury)

HIPPA PRIVACY PRACTICES

I acknowledge that I have reviewed the HIPPA Notice of Privacy Practices.

ClientName(PRINT)

Date

Client/Parent/Guardian/Personal Representative Signature

Date

If signed by Personal Representative, please describe relationship to client: _____

CONSENT FOR TREATMENT

1. I voluntarily consent to participate in the initial intake and assessment process.
2. I have been given the opportunity for discussion of any concerns that I have regarding treatment.
3. I will be informed and take part in my treatment and goal planning.
4. I understand:
 - That I may withdraw my consent in writing at any time.
 - That I must notify Mindful Balance Psychological Wellness if my insurance carrier or coverage changes.
 - I am responsible for monitoring my insurance. It is my responsibility to ensure participation and non-participation. I am responsible for payment of any services not covered by insurance and will pay any and all charges, co-pays, and deductibles owing Mindful Balance Psychological Wellness in accordance with their regular rates. **Any insurance balance not paid within 120 days will become my responsibility.**
 - Any and all balances will need to be paid off at the time of appointment. Next appointments cannot be made unless balances are paid.
 - If I must cancel an appointment, I am required to contact the office 24 hours prior to the appointment. Voicemail is available 24 hours a day, 7 days a week. **If I fail to contact the office, I will be charged a \$75 no-show fee. No exceptions.** This fee is not billable to your insurance and is due at the beginning of your next session.
 - Balances over 30 days will accrue a service charge of 1.5% monthly, 18% annually. In addition to the above service charge, I agree to pay all costs of collection, including filling fees, court costs, and reasonable attorney fees.
 - **I will be charged \$25 for any non-sufficient funds charges on checks.**
 - In case of inclement weather, I am to call the office prior to my appointment to confirm that the office is open. If the office has closed, there will be a message on our recording indicating the closure.
 - If I have a late cancellation, or no-call no-show twice within a one year period, my case will be closed.
 - If my therapist must write a letter(s) or fill out insurance forms, there will be a \$15 charge for this service. Also, I must allow up to a week for this service to be completed.

Client/Parent/Guardian/Personal Representative Signature

Date

CLIENT HISTORY

Client's Name: _____ DOB: _____

ADULT ONLY
(CHILD ONLY - SKIP TO SECTION 2)

	NAME	SEX	AGE	LIVES WITH YOU	DECEASED
Spouse/ Significant Other					
Children					
Mother					
Father					
Siblings					

EDUCATIONAL BACKGROUND

Highest Level Completed: HIGH SCHOOL TRADE COLLEGE GRADUATE

College Degree: _____ Graduate Degree: _____

Any vocational training: _____

Are you satisfied with your education? Y N
If NO, why not? _____

LEISURE AND RECREATION

List your hobbies and interests: _____

Has your level of activity changed? Y N

If YES, explain: _____

EMPLOYMENT HISTORY

EMPLOYER (MOST RECENT)	DATES	JOB DESCRIPTION

Are you currently employed outside the home? Y N Are you FULL PART

Special circumstances (laid off, medical leave, suspended, retired, other): _____

Do you currently have financial problems? Y N

PHYSICAL HEALTH

Who is your current physician? _____

Address Phone/Fax

Date of last physician appointment: _____ Reason for seeing your physician: _____

List your current medications: _____

PHYSICAL HEALTH CONTINUED

Are you allergic to any medications? Y N

If YES, explain: _____

COUNSELING - PRIOR TREATMENT HISTORY

Have you ever had thoughts of, or attempted, harming yourself or another person? Y N

If YES, explain: _____

Do you have a history of any suicidal attempts? Y N

If YES, explain: _____

Have you had counseling before? Y N

If YES, please provide information below:

NAME OF LOCATION	INPATIENT/OUTPATIENT	DRUG/ALCOHOL TREATMENT?

Other comments: _____

Client Signature

Date

SECTION 2
(CHILD ONLY)

Name of person completing this form: _____

Relationship to child: _____

FAMILY HISTORY

	NAME	AGE	EMPLOYER/SCHOOL	MARITAL STATUS
MOTHER				
FATHER				
STEP-PARENTS				
SIBLINGS				

SCHOOL ADJUSTMENT

School District: _____ School Name: _____ Has your child been afraid to go to school?
Y N

If YES, explain: _____

(SCHOOL CONTINUED)

Current grade: _____

Repeated any grade(s)? Y N

If YES, explain: _____

Has your child ever had difficulties with:

MATH READING LANGUAGE SPEECH

Has your child ever had special education services? Y N

If YES, explain: _____

Have you received any complaints from your child's school about behavior or achievement? Y N

If YES, explain: _____

How does your child relate to peers? _____

LEISURE

How does your child spend his/her free time? (hobbies)

COUNSELING - PRIOR TREATMENT HISTORY

Has your child ever had thoughts of, or attempted, harming themselves or others? Y N

If YES, explain: _____

Does your child have a history of suicidal attempts? Y N

If YES, explain: _____

Has your child had counseling before? Y N

If YES, please provide information below:

NAME OF LOCATION	INPATIENT/OUTPATIENT	DRUG/ALCOHOL TREATMENT?

ADJUSTMENT DIFFICULTIES

Please check any that apply to your child:

<input type="checkbox"/> Doesn't feel liked	<input type="checkbox"/> Ritualistic behavior	<input type="checkbox"/> Sets fires
<input type="checkbox"/> Feels lonely	<input type="checkbox"/> Talks impulsively	<input type="checkbox"/> Poorly organized
<input type="checkbox"/> Shy with children	<input type="checkbox"/> Acts impulsively	<input type="checkbox"/> Clumsy
<input type="checkbox"/> Prefers to be alone	<input type="checkbox"/> Feelings of guilt	<input type="checkbox"/> Takes unnecessary risks
<input type="checkbox"/> Worries	<input type="checkbox"/> Doesn't feel like self	<input type="checkbox"/> Short attention span
<input type="checkbox"/> Moody	<input type="checkbox"/> Easily angered	<input type="checkbox"/> Daydreams
<input type="checkbox"/> Sad	<input type="checkbox"/> Stubborn	<input type="checkbox"/> Jealousness
<input type="checkbox"/> Cries easily	<input type="checkbox"/> Defiant	<input type="checkbox"/> Overactive
<input type="checkbox"/> Expects failure	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Poor hygiene
<input type="checkbox"/> Doesn't share	<input type="checkbox"/> ___ with Peers	<input type="checkbox"/> Sleep difficulties
<input type="checkbox"/> Lacks motivation	<input type="checkbox"/> ___ with Siblings	<input type="checkbox"/> Sleep walking
<input type="checkbox"/> Sexually acting out	<input type="checkbox"/> ___ with Adults	<input type="checkbox"/> Bedwetting-present
<input type="checkbox"/> Preoccupied with	<input type="checkbox"/> Needs the "last word"	<input type="checkbox"/> Bedwetting-past
<input type="checkbox"/> ___ sexual thoughts	<input type="checkbox"/> Stealing from home	<input type="checkbox"/> Soiling
<input type="checkbox"/> Ticks or twitches	<input type="checkbox"/> Stealing from peers	<input type="checkbox"/> Unusual thinking
<input type="checkbox"/> Compulsive behavior	<input type="checkbox"/> Will not admit blame	<input type="checkbox"/> Unusual behavior
<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Destructive to property	<input type="checkbox"/> Not always truthful
<input type="checkbox"/> Fails to understand consequences		

Other comments: _____

Parent/Guardian Signature

Date