PSYCHOLOGY CENTER
of
IDAHO FALLS

3670 S. 25th E., Suite 2 • Idaho Falls, ID 83404 • 208.522.3404

Counseling Registration

Name_____ Male _____ Female _____

Mailing Address _____ Married? Yes _____ No _____

_____

_____ Spouse's Name: _____

Cell #: _____ Home #: _____

Ok to leave voice messages? Yes _____ No _____ Ok to text for reminders/info? Yes _____ No _____

Email Address: _____

Age: _____ Date of Birth: _____ Birthplace: _____

Referral Source: _____ Social Security #: _____

Current Concerns: _____

_____

_____

Current Medications: _____

_____

Employer/School Information:
Occupation: _____
Employer: _____

Highest Grade Completed: _____
Current School (if a student): _____

Primary Care Physician: _____

Will a copy of this report need to be sent to any other health care provider or school? Yes_____ No_____

Do you request insurance submission? Yes_____ No_____

If yes:
Insurance Provider: _____ Policy #:_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Policy Holder Address:_____

INFORMED CONSENT FOR TREATMENT

This form will provide information about our services and about your rights and responsibilities as a client. Please be sure to discuss any questions with the provider. Your signature at the bottom indicates that you understand the information and freely consent to participate in treatment.

I understand that treatment may involve discussing relationship, psychological, and/or emotional issues that may at times be distressing. I also understand that this process is intended to help me personally and/or with my relationships. I am aware of alternative treatment options and other treatment providers available. All of my questions about treatment options have been answered satisfactorily. If I have further questions, I understand that the provider will either answer them or find answers for me. I understand that I may leave therapy at any time, although I understand that this is best accomplished in consultation with my therapist. I also understand that my therapist reserves the right to discontinue treatment, if clinical judgment calls for such action (e.g. based on client status/progress, changes in client needs, provider practice issues, etc).

CONFIDENTIALITY & PRODUCTION OF RECORDS:
The information obtained in this evaluation is confidential and will not be released to any person or organization without your written consent. The only exceptions to this policy are rare situations in which we are required by law to release information without your permission. These are 1) if there is evidence of physical and/or sexual abuse of children, or abuse to the elderly; 2) if it is judged that you are in danger of harming yourself or another individual; or 3) if your records or a PCIF provider's testimony are sought by subpoena or court order. We will attempt to notify you before any action is taken and would limit disclosure of confidential information to the minimum required to comply with the law.

FEE AND PAYMENT POLICY:
The standard fee for counseling is $175 for a 55-60 minute session. The standard fee for a 40-50 minute session is $125. ***Payment for co-pays, deductibles, etc. is the client's responsibility, and will be due in full at the time of service.*** Submission to private insurance companies may be done, upon request. Pre-authorization, if required, is the responsibility of the client. Any unpaid balance (e.g. due to insurance denial or non-payment) is the client's responsibility.

MISSED APPOINTMENTS:
For the courtesy of other patients that are waiting for appointment times, Cancellations must be made at least 24 hours prior to the scheduled appointment. Late cancellations (less than 24 hours notice) and "No-Shows" will be assessed a $50 fee to be paid prior to scheduling their next appointment. Two Late cancellation or "No-Shows" will result in the client no longer being eligible for services at PCIF.

AGREEMENT:
I have read the above material, and I fully understand my rights and obligations as a client. I freely agree to treatment, with the specified conditions.

Name of Client Date

Signature Date
(Client or parent/legal guardian)

Acknowledgement of Notice of Privacy Practices: HIPAA

The Notice of Privacy Practices tells you how we may use and share your health records. Please read it.

- We will use and share your health records to treat you and to bill for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

All the ways that we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of who we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

I have had the opportunity to receive a copy of the Notice of Privacy Practices.

_____

Name of Client

_____

Signature (Client or parent/legal guardian) Date

Consent

I give, Psychology Center of Idaho Falls, my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Psychology Center of Idaho Falls' Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Psychology Center of Idaho Falls has the right to change privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

_____

Name of Client

_____

Signature (Client or parent/legal guardian) **Date**

PSYCHOLOGY CENTER
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Consent to Release Medical Information

Name of Client: _____ **Date of Birth:** _____

Information to Be Released: □ **Communication with Provider**
□ **Psychological Testing Report**
□ **Other:** _____

Designated office from which information is being requested:

Name: **Psychology Center of Idaho Falls**
Address: **3670 S. 25th E. Suite 2**
Idaho Falls, ID 83404
Phone: **(208) 522-3404**

Name of Physician, Health Care Provider, Hospital and/or Other Designated Person/Office authorized to communicate and/or receive records specified above:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Purpose of Disclosure: _____

Statement of Consent:

The undersigned does hereby authorize and consent to the disclosure of any and all information, records, documents, reports, clinical abstracts, histories and charts, of every kind and description, relating to the condition, care, confinement and treatment of the above-named patient, by the above-named individual or entity or their representative, to the above-named physician or physicians, health care provider, hospital, and/or other designated person(s), and does consent to the inspection and duplication of the indicated records by the same.

Treatment is not conditional upon signing this release and the client has the right to revoke this release at any time.

The undersigned further agrees to waive any and all privileges granted under the provision of law which may either directly or indirectly pertain to this disclosure as hereby authorized. This release will remain valid for 6 months from the date of signature.

Signature_____

Date _____

Office use only:
Reason unable to obtain signature: _____