Christian Psychotherapy Resources

1360 Caduceus Way, Bld 400, Ste 102, Watkinsville, GA 30677

REGISTRATION FORM

Today's Date:	PCP:	PCP phone number:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Allergies:		
Current Medication:		
Employer:	Employer phone number:	Referral Source:

CONSENT TO TREATMENT: I understand that treatment with Dr. Robinson may involve discussing medical, relationship, psychological and/or emotional issues that at times may be distressing. However, I also understand that this process is intended to help me personally. I further understand that if I have questions, Dr. Robinson will answer them. I understand that I may leave therapy at any time although I have been informed that this is best accomplished in consultation with Dr. Robinson. I have also read the Client Rights and Responsibilities handout. Initial__________

CANCELLATION POLICY REQUIRES A 24-HOUR NOTICE FOR CANCELLING OR RESCHEDULING APPOINTMENTS. MISSED APPOINTMENTS OR LATE CANCELLATIONS ARE SUBJECT TO THE FULL FEE SINCE THE APPOINTMENT TIME WAS RESERVED EXCLUSIVELY FOR YOU. Initial_________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No

Please indicate primary insurance: | Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Christian Psychotherapy Resources or the insurance company to release any information required to process my claims.

Patient/Parent/Guardian signature

Date

CLIENTS RIGHTS AND RESPONSIBILITIES

Clients Rights:

Confidentiality is a privilege protected by law and ethics of the counseling's profession that allows for strict private discussions of issues that concern you. Your records may be released only with written permission.

Exceptions include:

- Disclosure to appropriate authorities or family members when there is sufficient cause to believe that you pose a threat of physical harm to yourself or others.
- Additionally, it is required by law to report any form of neglect or abuse to children, elder persons, or disabled adults.
- If there is a court order by a judge, therapist are bound by law to release information.
- In keeping with generally accepted standards of practice, therapists consult occasionally with supervisors and professional colleagues regarding the management of cases in order to ensure quality of care. Every effort is made to protect the identity of clients.

Informed Consent refers to your rights to explanation of your condition and treatment that you can understand. You have a right to participate in the planning of your treatment, refuse treatment, and file complaints or compliments. Treatment often involves addressing concerns that are distressing and you can discontinue at any time, although this is best done in consultation with Dr. Robinson.

Respect and non-discrimination are part of your treatment regardless.

Telephone consultations refer to the occasional need to consult briefly by phone. For these necessary and brief consultations, there is no charge. However, if you wish further assistance, you can schedule an additional session.

Client Responsibilities:

Cancellation policy requires a 24-hour notice for cancelling and rescheduling appointments. Missing or late cancellations are subject to a full fee since the appointment time was reserved exclusively for you. THE OFFICE CANNOT BE HELD RESPONSIBLE FOR APPOINTMENT REMINDERS. Note that you can leave a message on the voicemail 24 hours a day seven days a week at 705-286-8442. Continued failure to cancel appointments in a timely manner or frequent rescheduling of appointments could result in termination of services.
Fee payment is due at time of service unless arrangements have been discussed. It is the patient's responsibility to notify the receptionist of any change in address of phone numbers. We appreciate the opportunity to serve your behavioral needs. Please assist us in providing a more efficient service to you by contacting your insurance carrier to understand the extent and limitations of your benefits and to obtain requiring authorizations.

We appreciate the opportunity to serve your behavioral needs. Please assist us in providing more efficient services to you by contacting your insurance carrier to understand the extent and limitations of your benefits and to obtain required insurance authorization. Failure to obtain proper authorization may unfortunately result in

CLIENTS RIGHTS AND RESPONSIBILITIES

additional charges to you. We also require that when you attend your session you be prepared to provide your co-pay and/or deductible determined by your insurance carrier. It is the patient's responsibility to inform the receptionist of any changes in address, phone numbers, and/or insurance coverage.

Patient/Parent/Guardian Signature: ______________________________ Date: ______________________

Witness: ______________________________

HIPPA NOTICE OF PRIVACY PRACTICES

Dr. Margaret M. Robinson, PhD.
1360 Caduceus Way, Building 400, Ste 102
Watkinsville, Georgia 30677-7351
Phone: (706) 286-8422
Fax: (706) 310-6907

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your right to access and control your personal health information. "Protected Health Information" is important about you, including demographic information, that may identity you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Users and Disclosures or Protected Health Information: Your protected heath information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the therapists, practice, and any other use required by law.

Treatment: We keep records of your care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. We will use and disclose your protected health information to provide, coordinate, and manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your therapist may share your health information with a specialist, referring physician or therapist, or hospital staff who will assist in your treatment. Your protected health information may be provided to a physician or therapist to whom you have been referred or who is proving on-call coverage to ensure that the physician or therapist has the necessary information to diagnosis or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your protected health information will be provided to the staff at Oconee Behavioral Health Center which manages the billing and records stored in our office. Also, for example, we may disclose information about the services provided to you to claim and obtain payment from your insurance company, managed care company, health plan, or Medicare.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employees review activities, training of health care students, licensing, outside storage of medical records, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Sharing Your Health Information: There are situations when we are permitted or required to disclose health information without your authorization. These situations are: when a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting, investigation or surveillance; for notice to and from the federal Food and Drug Administration regarding drugs or medical devices; to protect victims of abuse, neglect, or domestic violence; for health oversight activities such as investigating, licensing, audits, and inspections; for lawsuits, legal proceedings, and when otherwise required by law; when requesting by law enforcement as required by law or court order; to report criminal activity; to report to

coroners, medical examiners, and funeral directors; for inmates; for organ and tissue donations; for research approved by our review process under strict federal guidelines; to reduce or prevent serious threat to public health and safety; for workers' compensation or other similar programs if you are injured at work; for specialized government functions such as military activity, intelligence, and national security; for incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; and disclosures to "business associates" who perform health operations for us and who commit to respect the privacy of your health information. Required uses and disclosures: Under the las, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

All other uses and disclosures will be made only with your signed consent or authorization. You may revoke this authorization, at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

You have right to inspect and copy your protected health information. Fees may apply. Under limited circumstances, we may deny your access to a portion of your health information and you may request a review of the denial. Under federal law, however, you may not inspect a copy of the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceedings, and protected health information that is subject to law that prohibits access to protected health information.

Your therapist is not required to agree to a restriction that you may request. If the therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agree to accept this notice alternatively, i.e. electronically.

You have the right to have your health care provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of each such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Fees may apply.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speech with our HIPPA Compliance Officer in person or by phone at 706-549-5248.

Signature below is only an acknowledgement that you have received this Notice of Privacy Practices:

Print Name: ______________________________ Signature: ________________________ Date: _____________