

Client Registration Form

Last Name: _____ First Name: _____ MI: _____

Address: _____

Home#: _____ Work#: _____ Cell#: _____

Gender: M F Date of Birth: _____

Marital Status: Single Married Other

Religion: _____ Last 4 Digits of SSN: _____

Occupation/Employer: _____

Emergency Contact: _____

Preferred Emergency Room/Hospital: _____

Have you had previous psychological consultations/treatment? Y N

Treating Physician/Clinic: _____

Terms and Conditions of Service

Notice of Privacy Practice and Disclosure of Information:

I have received a copy of the Notice of Privacy-Practices for Protected Health Information.

I understand that my health information (including mental health information) may be disclosed for the purposes of treatment, for obtaining payment from my insurance carriers, and/or to other qualified health care professionals, with my written authorization, within limits of the law.

I understand that according to Minnesota law, I may choose to pay for services if I do not wish my health information to be given to my insurance company. I agree to notify this office about my wishes regarding payment and I understand that if I fail to pay for the services, the information will be sent to my insurance carrier.

Nondiscrimination Policy:

This facility will treat clients within its capabilities, regardless of race, national origin, religious belief, gender, sexual orientation, marital status, age, veteran's status, political beliefs, or disability.

Communications:

In an effort to facilitate prompt communication of information related to your care, and in an effort to respect your privacy, we ask you to respond to the following. Check ALL items that apply to you. Non-urgent results, confirmation, reminder calls and general information/instructions regarding your health care can be left on:

- A message at my home number
- My work voicemail
- My cell phone voicemail
- Do NOT leave any messages on my home, work or cell phone

Information regarding non-urgent results confirmation, reminder calls and general information/instructions regarding my health care can be share with:

Spouse/Significant Other (name of party) _____
 Other, Specify name(s) _____

Client or Legal Representative's Signature

Relationship to Client, (if app.)

Print Name

Date/Time