New Client Registration

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____City/State: _____ Zip: _____

Gender/Pronouns:_____ Sexuality: _____ Relationship Status:_____

Social Security #: _____ E-mail: _____

Home Phone: _____ Cell Phone: _____

May we call you at either number? Y N Leave a message at either number? Y N

Person responsible for bill: ( ) Same as Patient

Name: _____ Relationship _____Phone: _____

Address: _____City/State: _____ Zip: _____

Employer Information:

Employer: _____

Address: _____ City/State: _____Zip: _____

Work Phone: _____May we call you at this number? Y N Leave a message at this number? Y N

In Case of Emergency, Notify:

Name: _____Relationship _____

Phone Number: _____

Household Information

Name	Date of Birth	Relationship	Occupation/Grade in School

New Client Registration (cont.)

List **all** medications you are now taking – prescription and nonprescription (such as aspirin, supplements, etc.)

Medication	Dosage (amount & times per day)	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe typical use of alcohol (amount, frequency):_____

_____

Do you or anyone else believe that your drinking is a problem? _____

_____

Please describe typical exercise (type, amount, frequency): _____

_____

What are your hobbies?_____

_____

Family History

Please indicate any psychological or medical difficulties experienced by other members of your family:

Father: _____

Mother:_____

Sisters: _____

Brothers:_____

Aunts/Uncles:_____

Grandparents: _____

Children:_____

Current Symptoms

Please circle any of the following areas in which you are having difficulty:

Nervousness	Shyness	Weight	Change	Drug Use
Communication	Anger	Inferiority	Sleep	Can't Relax
Motivation	Legal Matters	Energy	Loneliness	Low Interest
Fainting	Education	Dizziness	Hyperventilation	Seeing Things
Restlessness	Irritability	Isolation	Appetite Change	Depression
Hopelessness	Sexual Problems	Boredom	Alcohol Use	Fatigue
Impatience	Self-Control	Stress	Hearing Voices	Headaches
Overwhelmed	Memory	Pain	Self Esteem	Identity
Marriage	Career Choices	Hair Pulling	Panic	Crying
Concentration	Shaking	Parenting	Paranoia	Eating Problems
Racing Heart	Fear	Suicidal Thoughts	Finances	Mood Swings
Health Problems	Friends	Can't Have Fun	Nausea	Heart Palpitations
Avoid People	Perspiration	Dating Problems	Assertiveness	Work
Compulsive Habits	Making Decisions	Perfectionism	Guilt	Stomach Problems
Violence	Skin Picking	Family	Repetitive Thoughts	Other: _____

Briefly describe your reasons for seeking therapy: _____

_____

_____

New Client Registration (cont.)

History

Have you ever seen a mental health provider such as, psychologist, psychiatrist or therapist before? **Y or N**

Date	**Name**	**Reason**	**Outcome**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any major changes in your life in the past two years: _____

_____

_____

_____

When did you last feel well? _____

Please add any additional information you feel would be useful:_____

_____

_____

_____

_____

_____

Insurance Information

Primary and Secondary Insurance with Subscriber Info (attach copy of both sides of insurance cards, claims address required)
Is Insurance being used? Y N

Primary Insurance Company Name: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Patient _____Primary Phone:_____

Member ID/Policy: _____ Group Number _____ Effective Date: _____

Secondary Insurance Company Name: _____

Subscriber Name: _____Subscriber Date of Birth: _____

Relationship to Patient: _____ Primary Phone: _____

Member ID/Policy: _____ Group. Number: _____Effective Date: _____

Authorization for Release of Information

I authorize Seven Hills Psychology, LLC to release to my insurance carrier or its designated agents any information concerning mental health care, advice, treatment or supplies provided to me for the purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize a copy of this information to be as valid as the original. I will notify Seven Hills Psychology in writing of any information I do not want released.

_____ _____

Signature Date

Assignment of Benefits

I authorize the assignment of benefits payable to Seven Hills Psychology, LLC and/or its designee for behavioral health services and supplies or any other private third payer. I understand that I'm responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services.

_____ _____

Signature Date

Health Information

Primary Care Provider: _____ Phone:_____

Address:_____ Date of last physical exam: _____

Please list any health problems: _____

_____

_____

Authorization to Disclose Protected Health Information (PHI) to Primary Care Provider (PCP)

Communication between Behavioral Health Providers and your Primary Care Provider (PCP) is important to ensure that you receive comprehensive and quality health care.

This information will not be released without your signed authorization. This PHI may include diagnosis and treatment plan.

I, the undersigned understand that I may revoke this consent at any time. I have read and understand the information and give Seven Hills Psychology, LLC my authorization:

_____I agree to release any applicable mental health/substance abuse information to my PCP

_____I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services, and I direct you **NOT** to notify him/her

_____ _____

Signature Date

Your rights:

- You can end this authorization (permission to use or disclose information) any time contacting our office
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You do not have to agree to this request to use of disclose information