Tracy Crain, M.S., LPC-S, LCDC
REGISTRATION FORM

(Please Print)

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Nickname/Preferred Name:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:		Employer phone no.: ( )			
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Hospital			
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Other family members seen here:						

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 understand that I am financially responsible for any balance.			
Patient/Guardian signature		*Date*	

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CLIENT DETAIL

(Please Print)

Name:	Date:
Reason for seeking counseling:	
How long have you been married/dating/living together:	
Names and ages of children:	
Describe any significant problems with any of these children:	
Describe any previous marriages or relationships:	
Any history of current or past abuse:	
Describe relationship with parent(s) and sibling(s):	
Describe any past or present legal issues and status:	
Indicate both past and present use of alcohol and/or drugs:	
Indicate any financial problems past or present:	
Describe any significant religious/cultural influences:	
List any medical problems that you are currently experiencing:	
List any medications that you are taking:	
Have you ever seen a psychiatrist or counselor before: If yes, when:	
Any inpatient or outpatient psychiatric hospitalizations:	

Check any of the following problems that you experience:

__appetite change
__excessive drinking
__anger management
__drug use
__nervousness
__fatigue
__panic attacks
__anxiety/tension
__loneliness
__nightmares
__headaches
__weight change

__sexual problems
__difficulty relaxing
__stomach problems
__pain
__low self-esteem
__relationship problems
__confusion
__feelings of unreality
__flashbacks
__depression
__job stress
__agitation/irritability

__memory problems
__sleep disturbance
__fears/phobias
__obsessive thoughts
__compulsive behavior
__marital/family trouble
__poor impulse control
__trouble concentrating
__difficulty trusting
__suicidal thoughts
__suicide attempts
__withdrawing/isolating

MENTAL HEALTH DISCLOSURE FORMS

Brief therapy is goal-directed, problem focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made to accomplishment of that goal in a time efficient manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask.
Initial here: __________

Limits of Confidentiality Statement

All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:

1) The patient authorizes a release of information with a signature.
2) The patient's mental condition becomes and issue in a lawsuit.
3) The patient presents as a physical danger to self (Johnson v. County of Los Angeles, 1983)
4) The patient presents as a physical danger to others (Tarasoff v. Regents University of California, 1967)
5) Child or Elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes)

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling sessions. **Initial here: ________________**

Release of Information

I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. **Initial here: ____________________**

Emergency Access

I am available after hours to handle emergencies. By calling the main office number after office hours, you will be instructed how to contact me. **Initial here: __________**

Financial Terms: Insurance Coverage and Co-payments

You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance; however, you are responsible for co-payment amounts and deductibles as set in your benefit plan. Missed appointments are not covered by your insurance and the charges associated with them are your responsibility.

Late cancellations without 24 hours notice or not showing up for your appointment will be charged at $75.00. These payments are due and payable at each appointment. If you have a missed appointment charge, we expect that payment before your next appointment. **Initial here: _______**