Registration Form

Date ____/____/____

Section I: Patient Information

Name:		Age:
Address:		DOB:
City, State, Zip:		Sex: M ____ F ____
e-mail:		
Telephone: ( )		Marital Status:
Work Phone: ( )		Date of Wedding:
Cellular Ph. / Pager: ( )		
		Previous Marriage/Relationship:
Employment Status:		Yes ____ No ____
Occupation:		Length of Commitment:
		Reason for ending relationship:
Spouse / Significant Other Information:		
Name:		Age:
Address:		DOB:
Occupation:		Previous Marriage/Relationship:
Employer:		Yes ____ No ____ # of yrs. _____
How did you hear about aHeARTT?		

Section II Communication

Can therapist/office leave a message:	❑	yes	❑	no	Phone:
	❑	yes	❑	no	E-mail:
	❑	yes	❑	no	Other:

Do you wish to receive occasional **e-newsletters** including tips and ideas for improved well-being? (You have the option to automatically add or remove yourself from the list and your information is always private.)

❑ Yes ❑ No

FEES: Direct pay (cash, check, credit card). Individual rates are $80/50minute session.

MISSED APPOINTMENTS:

For ALL appointments, unless cancelled with at least **24 business hours** notice, a charge will be applied to your account. This charge will be billed as your responsibility. Please help us serve you better by keeping scheduled appointments. **To change (cancel or reschedule) your appointment please call: 651-470-4671**

If you made your appointment on-line, you can also cancel on-line.

Registration Form

aHeARTT

Section III: Family Information

Who are the members in your family?	Age	Relationship	Notable health condition or concerns

Section IV: Reason for Visit/Goals for Assistance

Please describe the reason for your visit: ____
____
____

What is your primary concern or worry related to the current issue? ____________________________
____
____

List five words that describe your thoughts and feelings related to your primary concern? ______________
____
____
____
____

What are goals you hope to achieve from our visits? ______________________________________
____
____

How have the following symptoms bothered you **recently**?

❑ - Significant/Major Problem ❍ - Slight/Moderate Problem

❑ ❍ Depressed, sad, or crying	❑ ❍ Inability to concentrate	❑ ❍ Anger or temper problems
❑ ❍ Suicidal thoughts, plans, or attempts	❑ ❍ Anxious, nervous, or panicky feelings	❑ ❍ Repetitive thoughts, behaviors
❑ ❍ Guilty feelings	❑ ❍ Insecurity or inferiority	❑ ❍ Memory problems
❑ ❍ Loss of interest or energy	❑ ❍ Change in spending habits	❑ ❍ Sexual worries / problems
❑ ❍ Physical problems, pain, or illness	❑ ❍ Periods of euphoria, boundless energy or unstoppable activity	❑ ❍ Confused or disorganized thoughts

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aHeARTT

Section V   Responsible Party/Billing

Name:			Relationship to Patient:
Address: (if same as patient information write same)			
City:	State:	Zip:	Phone:
Employer:	Work Phone:		Cell Phone:
SSN#			

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Section VI   Privacy & Disclosure

The privacy of your information is important. We keep your information secure and confidential to the best of our ability. HIPAA guidelines are followed. For more information on HIPAA please go to:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

By law we are considered a mandatory reporter. That means abuse to children/vulnerable persons must be reported. Actions must also be taken if there is considered to be imminent danger to self or others.

X ____

Signature of Patient/Client or Personal Representative   **Date**

If signed by personal representative, relationship to patient:_______________________

Section VII   Bill of Rights

Consumers of professional mental health services have the right:

(a) to expect that the professional consulted has met minimal qualifications of training and experience commensurate with service requirements and in accordance with professional and/or disciplinary standards.
(b) to be informed of the credentials of those by whom they are served;
(c) to be informed of the cost of professional services prior to receiving those services;
(d) to privacy as defined by rule and law;
(e) to be free from being the subject of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services;
(f) to have access to their records as a provided in Minnesota Statutes, section 144.335 subdivision 2; and
(g) to be free from exploitation for the benefit or advantage of a therapist.