PATIENT REGISTRATION

Counseling Services of Dothan
1450 Ross Clark Circle, Suite #3
Dothan, Al. 36301
(334) 794-2113 Phone
(334) 702-1220 Fax

Jeff Justice, LPC.
Tim Faulk, PhD. LMFT
Randall Jordan, Psy. D
Teresa Holmes, LPC
Tami Chancy Jordan, LPC
Larry Beauchamp, LMFT

Patient Information:

First Name: _____ Last Name: _____ Preferred Name: _____

Address:_____

City, State, Zip: _____

Home Phone: _____Work Phone: _____Ext: _____Cell:_____

Birth Date: _____ Driver's License: _____

Social Security# _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Other

Patient Employer or School:

_____

_____

Responsible Party: (if different than patient) **Social Security#** _____

Relationship to Patient: □ Spouse □ Parent □ Other _____ **DOB#** _____

First Name: _____ Last Name: _____

Address (if different from above):_____

City, State, Zip: _____

Home Phone: _____ Cell:_____

Primary Insurance Information:

Insurance Company Name: _____

Member ID#: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Birth Date: _____

Policy Holder Soc. Sec. # _____

Secondary Insurance Information:

Insurance Company Name: _____

Member ID#: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Birth Date: _____

Policy Holder Soc. Sec. # _____

Please List Names/Relationships Of Anyone You Would Like To Have Access To Patient Information:

Name:	Relationship To Patient:
_____	_____
_____	_____
_____	_____

Doctor's Name for Release:

_____

I, _____ give permission for the above said doctor to receive communication regarding care, and/or testing.

Patient Signature: _____ Date: _____

Please Read:

I understand that due to the limitations of confidentiality:

1. If we learn of child abuse, or abuse of disabled adults, we are required by law to report it to the proper authorities.
2. If, in our judgment, a client is a danger to himself, and/or others we will call the proper authorities.
3. If we are required to presents records to comply with a court order, it is our legal obligation to do so.
4. If you are a minor (under the age of 14 for mental health purposes), special care will be taken to protect the information you provide, however, your parent(s)/legal guardians are legally entitled to the information you provide.

Financial Statement:

We do file ALL insurances; however, we collect all co-pays, and/or deductibles not covered by your insurance at the time of your visit. If payment arrangements need to be made, please discuss this with the insurance department at the time you check in before services are rendered. Understand verification of insurance is never a guarantee of payment, and if your insurance does not cover you will be responsible for the remaining charges. Please understand that we will work with you the best we possibly can, but if your account becomes 120 days delinquent with no efforts to resolve the balance it will be placed with **Prim & Mendheim, LLC** for collection purposes with interest accruing on the balance at the rate of **1.5% per month (18% per annum)**. You will also be responsible for reasonable collection costs as well as attorney fees. If account is placed for collection you may not return as an active patient until any balances are resolved.

Payment Options:

We do accept Visa, MasterCard, American Express, and Discover cards. A $40.00 service fee will be charged for a returned check and no starter checks will be accepted.

In Case Of Emergency:

If an emergency occurs after business hours (8:00 am-5:00 pm Monday-Thursday, and 8:00am-2:00pm on Friday), and you need to contact your counselor, please call (334) 794-2113, and follow the prompts to leave a message for your therapist on their voicemail and they will receive a notification on their cell phone.

HIPAA Policy:

Effective September 23, 2013, all healthcare providers must be compliant with the final regulations released for all Health Information Portability Accountability Act known as HIPAA. We cannot release any information without the explicit permission of the patient except in certain circumstances i.e.: a court order, DHR. A paper copy of the HIPAA practices is available upon request. Please feel free to ask the office staff for a copy if you would like.

By signing below, I acknowledge I have read all of the above, and agree there upon.

Patient Signature: _____ Date: _____

CURRENT SYMPTOMS – CHECK ALL THAT APPLY:

Patient Name: _____ Age: _____

_____ Please Check If You Are Here For A Pain Management Evaluation Only (You May Skip The Symptoms)

_____ Depression	_____ Mood Swings
_____ Loss of Interests	_____ Anger
_____ Crying Spells	_____ Irritability
_____ Appetite, or Weight Loss/Gain	_____ Decreased Concentration
_____ Hopelessness	_____ Helplessness
_____ Low Self Esteem	_____ Lowered Hygiene
_____ Isolating Self	_____ Thoughts of Death/Dying/Suicide
_____ Problems Sleeping	_____ Nightmares
_____ Fatigue/Loss of Energy	_____ Excess Worry
_____ Racing Thoughts	_____ Spending Sprees
_____ Sexual Promiscuity	_____ Legal Problems
_____ Impulsive Behaviors	_____ Easily Distracted
_____ ADHD	_____ Road Rage
_____ Violence Towards Others	_____ Victim of Abuse
_____ Bulimia/Anorexia	_____ Hallucinations
_____ Scared	_____ Feeling Like Someone Is After You
_____ Anxiety/Panic Attacks	_____ Obsessive Thinking
_____ Social Anxiety	_____ Compulsive Behaviors
Other: (Please Describe):	_____

Additional Notes/Information: _____
_____
_____
_____
_____
_____
_____
_____