WELLNESS
PSYCHOLOGICAL SERVICES

ADULT PATIENT REGISTRATION FORM

Please provide the following information and answer the questions below. Please fill out this form and bring it to your first session along with your driver's license and insurance identification card (if using insurance).

Patient's Name: _____
Last First Middle

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Social Security Number: _____

Address:_____
Street City State Zip

Home Phone: ( ) _____ May I leave a message? □ Yes □ No

Cell Phone: ( ) _____ May I leave a message? □ Yes □ No

Email address: _____ May I email you? □ Yes □ No

Would you like to receive appointment reminders by email? □ Yes □ No

Education: _____ Occupation/Position: _____

Employer: _____

Primary reason(s) for seeking services: (check all that apply):

____ Anxiety/Panic/Phobias	____Alcohol/Drugs	____ Anger Management	_____Self esteem
____ Relationship issues	____Stress	____ Trauma	_____OCD
____ Depression	____Bipolar Disorder	____ Health/sleep	_____ Grief ____Other

Concerns: _____

Referred to by: _____ Name of Spouse/Significant other: _____

Please list names and ages of children: _____

Are you currently taking any prescription medication? □ Yes □ No If yes, please list: _____

Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, please list and provide dates: _____

_____

Have you previously received any type of mental health service (therapy, psychiatric services, etc.)? □ Yes □ No

Have you ever been hospitalized for psychiatric reasons? □ Yes □ No

Patient's Signature: _____ Date: _____

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INFORMED CONSENT & OFFICE POLICIES

I _____voluntarily give my consent to Wellness Psychological Services, PLLC for the purposes of providing psychological services. These psychological services may include but are not limited to: assessment, individual psychotherapy, couples counseling, group therapy, consultation, or parent training.

Confidentiality: The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. **There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:**

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose information other than as specified in our contract.

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Electronic Communication: Clients are welcome to email regarding scheduling and for brief follow up messages. However, please understand that we cannot guarantee confidentiality to be 100% protected via electronic communication. While we do use an secure encrypted email service, please still avoid sharing any sensitive information via email. Confidentiality is also not 100% guaranteed with text messages. Email or text messages are not an appropriate form of communication for crises, please see the emergency procedure below.

Social Media: The providers do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc) for their personal pages. We believe that adding clients as friends or contacts on these sites could compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up in session. Wellness Psychological Services does have various business focused social media pages, whether that be our practice Facebook page or website blog. You are welcome to view those pages and engage but please be aware of the limits of confidentiality should you choose to like or comment on our business page. Our primary concern is your privacy, you are welcome to use your own discretion in choosing whether to follow Wellness Psychological Services in any of its business social media pages.

Emergency Procedure: Wellness Psychological Services, PLLC only provides outpatient mental health services and does not offer 24-hour emergency coverage. The regular office hours are Monday-Thursday 9:00am to 6:00pm and additional hours vary by week and provider. When your provider is in session during regular office hours they may not be available to return your call until the end of the business day. In the event of a behavioral health or medical emergency, you may call the Crisis Center of Tampa Bay at 813-264-1234, dial 911 or 211 or contact your primary care physician or go to the nearest emergency room. **Outside of regular office hours (evenings and weekends) your provider is not going to be checking office voicemail or email and so will not be aware of your message until regular office hours- therefore if you have a crisis or emergency you must contact one of those emergency resources.**

Benefits & Risks: Psychological services are intended to be beneficial in the improvement of mental health concerns; however none of these benefits are guaranteed. You may disagree with the opinions offered to you and emotional distress may result from sensitive matters which are addressed during the course of treatment. Alternative referrals to another health care professional are provided if requested.

Discharge: I am aware that if I prematurely discontinue treatment without informing Wellness Psychological Services, PLLC then an administrative discharge will automatically occur 45 days after the last psychotherapy session. If this occurs I am also aware that I can contact the office to reopen my file and resume treatment if desired.

By signing below, I confirm that I have read this form in its entirety, or it was read to me, and I understood the information provided. I have no additional questions and I have clarified anything with which I disagree. I agree that my consent is voluntary and can be revoked, in writing, at any time.

Print Patient's Name: _____

Patient's Signature: _____ Date: _____

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Patient Consent for Use and Disclosure of Protected Health Information (HIPPA Acknowledgement)

I hereby give my consent for Wellness Psychological Services, PLLC to use and disclose protected health information (PHI) about me (or minor child) to perform treatment, payment and health care operations (TPO). The Notice of Privacy Practices updated on November 1st, 2015 provided by Wellness Psychological Services, PLLC describes such uses and disclosure in more detail. Any uses or disclosures of PHI not described in the Privacy Notice require a signed Authorization before PHI can be released. Wellness Psychological Services, PLLC is required to provide notification if there is a breach of insecure PHI.

I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. Wellness Psychological Services, PLLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by sending a written request to Dr. Brittany Carswell.

In signing this consent, Wellness Psychological Services, PLLC is permitted to call my home or other alternative phone numbers listed and leave a message on voicemail. Wellness Psychological Services, PLLC is also authorized to mail to my home any items that assist in performing TPO, such as patient billing statements.

I am aware that if I am requesting Wellness Psychological Services, PLLC to submit my insurance claims that billing will be handled by Dr. Brittany Carswell. Only the minimum information necessary for a claim to be processed by the insurance carrier is provided to the insurance company. This PHI generally includes patient name and address, insurance identification number, mental health diagnosis and dates of service. I am also aware that Wellness Psychological Services may employ administrative assistants or virtual assistants as employees or contractors to handle calls and scheduling. If there are questions or concerns about insurance billing, I am aware that I can discuss my concerns with practice owner Dr. Brittany Carswell (813) 563-1155

I understand that I may revoke my consent, in writing, except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Wellness Psychological Services, PLLC may decline to provide treatment to me.

_____

Print Patient's Name

_____ _____

Signature of Patient or Parent/Legal Guardian Date

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FINANCIAL RESPONSIBILITY & GUARANTEE OF PAYMENT FOR SERVICES

Thank you for choosing Wellness Psychological Services, PLLC. The purpose of this notification is to clarify the financial arrangements before services begin. By signing below, you agree to be charged for direct and indirect services provided at Wellness Psychological Services, PLLC. Direct services include but are not limited to: face to face psychotherapy, couples therapy, assessment and consultation. Indirect services include but are not limited to: report writing, letter writing and phone calls over 10 minutes. The standard hourly rates vary depending on the type of service, time and provider and range from $150 to $225. Psychological evaluations vary in fees dependent on the scope and nature of questions to be addressed and amount is agreed to prior to scheduling.

Health Insurance: In signing this form, you are also authorizing Wellness Psychological Services, PLLC to contact your insurance company regarding payment of services. Wellness Psychological Services, PLLC may need to disclose case records (diagnosis, case notes, psychological reports, testing results or other requested material) to the third-party payer or insurance company for the purpose of receiving payment for services rendered. It is your responsibility to understand the benefits of your insurance plan. Any precertification which is required by your insurance company must be done prior to your appointment. If you using insurance for which Wellness Psychological Services, PLLC is out of network, then it will be your responsibility to pay in full at the time of service. You will be given a receipt to provide to your insurance carrier to receive reimbursement.

If using insurance, please provide policy information below and a copy of your card will be required:

Insurance Carrier: _____ Policy #: _____

Policy Holder Name: _____ Relationship to Patient: _____

Late Cancel Policy: Appointment times are specially held for each patient and it is important that you give **24-hour notice** if you intend to cancel. If notification of the cancellation is NOT received within the 24-hour time frame then you will be charged a **$50 fee for the late cancellation** and this CANNOT be billed to insurance. Allowances to the policy are made for true emergency situations.

You will be asked to give your credit card information after filling out all of the paperwork. This card will not charged at this time but will be stored in the secure system for future payments or copayments. Additionally, by signing below, you authorize Wellness Psychological Services, PLLC to charge your card for any unpaid balance after insurance discounts. If your insurance carrier does not pay within 30 days and you are notified by phone, you will be given an additional 10 days to settle the balance. If not, your card will be charged for the unpaid balance**. I certify that I have read and agree to the terms above.**

_____
Patient Name

_____ _____
Signature of Patient or Patient's Parent/Guardian if Applicable Date