TREASURE VALLEY
PSYCHOLOGY, PLLC

PATIENT REGISTRATION FORM

YOUR SIGNATURES/INITIALS INDICATE YOU HAVE READ THE INFORMATION.

PATIENT INFORMATION (THIS SECTION REFERS ONLY TO THE PATIENT)

Legal Name: _____ Preferred Name: _____

Street Address: _____

City, State & Zip: _____

Cell Number: _____ Home Number: _____

Sex Assigned At Birth: _____ Birth Date: _____

Current Gender Identity: _____ Marital Status: _____

Email Address: _____ Last Grade Completed: _____

Primary Care Doctor: _____ Referral Source: _____

BILLING INFORMATION (SEE BOX AT RIGHT)

(PERSON RESPONSIBLE FOR COPAY/COINSURANCE BILL PAYMENT)

PATIENT IS RESPONSIBLE ✔ _____

Name: _____ Birth Date: _____

Mailing Address: _____

City, State & Zip : _____

Home Phone: _____ Cell Phone: _____

Relationship to patient: _____

INSURANCE INFORMATION

CHECK HERE IF NO COVERAGE. ✔ _____

PRIMARY INSURANCE COMPANY: _____

Mailing Address: _____ Phone: _____

City, State & Zip: _____

Policy/Member Number: _____ Group Number: _____

Policy Holder: _____ Birth Date: _____

SECONDARY INSURANCE COMPANY: _____

Mailing Address: _____ Phone: _____

City, State & Zip: _____

Policy/Member Number: _____ Group Number: _____

Policy Holder: _____ Birth Date: _____

1. You are responsible for knowing your copay, deductible and coinsurance on your insurance. If your coverage depends on a doctor's referral, it is **YOUR** responsibility to obtain it.

INITIAL

2. Please make sure you listed **ALL** insurance coverage information for the patient. Failure to provide this information may result in your being liable for claims denied by your insurance company for "failure to file claim in a timely manner."

INITIAL

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1. We will bill the insurance company. If the insurance company does not pay, the patient/guarantor is ultimately responsible for payment of claim. A diagnosis code is required to bill insurance. If you do ***NOT*** want a diagnosis in your records, you will be required to pay our full charge for each session.

INITIAL

2. Co-payment is due at the time of service. Deductible, Co-insurance, Non-covered Procedures, etc, will be paid by the end of the month in which you receive the Balance Due statement (mailed out during the first week of each month.) Failure to pay the Balance Due could result in your account being sent to Collections. Collection agencies may request your records/confidential information.

INITIAL

3. ***There is a $25 fee for all Non-sufficient Funds checks returned to us.***

INITIAL

We must have your authorization to release information to your insurance company in order to submit a claim for provided services under your policy.

I authorize release of information necessary to file a claim with my insurance company, and assign benefits otherwise payable to me, to the provider or group on the claim.

I authorize payment of medical benefits to the provider filing claims for services provided to me.

I understand I am financially responsible for any balance not covered by my insurance carrier.

(PATIENT OR LEGAL GUARDIAN SIGN / ESIGN) (DATE)

As required by Idaho Statute 16-2428, children 14 years of age and older must sign below.

I hereby authorize release of information necessary to file a claim with my insurance company, and assign benefits otherwise payable to me, to the provider or group on the claim.

(MINOR 14 -1 7 YEARS OF AGE SIGN / ESIGN) (DATE)

LATE CANCELLATION AND NO-SHOW POLICY

- WE CHARGE $75 FOR ANY APPOINTMENT NOT KEPT (NO-SHOW), OR CANCELLED WITHOUT 24 HOURS ADVANCE NOTICE (LATE CANCELLATION). (FOR TESTING DATES, THE FEE IS $75 PER TESTING HOUR SCHEDULED.)
- We send appointment reminders via TEXT message.

I **acknowledge and understand** this 24-hour appointment cancellation and no-show policy, and that I will be billed $75 for each appointment slot I do not attend or cancel 24 hours prior to my appointment start time. My appointment will be "unexcused". **Two unexcused appointments in a row or three in a 3-month sliding-window period does constitute grounds for dismissal from service.** TVP tracks and records "no-shows" and "late cancellations," establishing basis for dismissal from service.

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(PATIENT/LEGAL GUARDIAN/GUARANTOR SIGN / ESIGN) (DATE) (LEAVE BLANK)

NOTICE OF PRIVACY PRACTICE (HIPAA) (WWW.TVPSYCHOLOGY.COM)

To read, select "NOTICE OF PRIVACY PRACTICE" on our website. You can also read it at our office, or you may request a copy to take home to read.

Your signature indicates you have read, or had the opportunity to read the information in this document,

(PATIENT OR LEGAL GUARDIAN SIGN / ESIGN) (DATE)

PSYCHOTHERAPIST-PATIENT SERVICE AGREEMENT (WWW.TVPSYCHOLOGY.COM)

To read, select "SERVICE AGREEMENT" on our website, or you may request a copy at our office.

Your signature indicates you have read, or had the opportunity to read the information in this document, and agree to abide by its terms and conditions during your professional relationship with our facility.

(PATIENT OR LEGAL GUARDIAN SIGN / ESIGN) (DATE)

ADDITIONAL INFORMATION

Relationship & Ages of Immediate Family Members (for demographics purposes only):

Drugs/Medications Presently Being Used: _____ SEE ATTACHED LIST

Medical/Health History (brief summary of history that could affect counseling/therapy):

CONSENT TO TREATMENT

Participation in psychological services can have benefits and risks. Therapy will often involve processing unpleasant and/or painful aspects of life which could result in the experience or re-experience of distressing feelings including sadness, guilt, anger, frustration, loneliness, and helplessness. However, the goal of psychotherapy can be to improve relationships, solve unique life problems, and reduce the impact of emotional distress. There is no way to determine what any individual may experience through the process of any psychological service offered, but it is important to note that the more invested an individual is in the outcome, the better the results are likely to be. The results of any psychological service will always vary based on many factors including the rapport between the psychologist and the patient, their individual personality types, as well as communication styles. Your psychologist is trained to deal with these issues as they arise, but there will generally be an expectation that you will communicate any concerns you may have at any point in the process with your psychologist, in order that these concerns are effectively resolved to your benefit. By signing this form, you acknowledge the potential for both risks and benefits in treatment, and that your psychologist is here to guide you through the process in the best way possible for your unique situation in order to minimize any potential adverse impact.

(PATIENT OR LEGAL GUARDIAN SIGN / ESIGN) (DATE)

1 We do NOT provide child care at our office. Children can be disruptive to your and other's therapy sessions, so you will need to make child-care arrangements for your children not being treated by provider.

2 Only certified service-dogs will be allowed in the office.

(PATIENT OR LEGAL GUARDIAN SIGN / ESIGN) (DATE)

PROFESSIONAL FEES FOR LEGAL INVOLVEMENT:

The providers at Treasure Valley Psychology do not engage in legal matters with/on the behalf of their patients. However, if you become involved in legal proceedings for which provider participation is compelled by the court, you will be expected to pay for all of the provider's professional time. This applies even if involvement is compelled by another party. Travel time, report and other preparation time, court testimony, wait time at the courthouse, depositions, consultations with attorneys, attendance at any legal proceeding, and any other legal involvement will be billed directly to you at a rate of $500/hr. A retainer of $2,000 will be required up front and prior to any provider time being spent on the case. These legal costs are nonrefundable, even in the event the actual testimony or deposition is cancelled, as such activities require extensive preparation regardless of final outcome.

(PATIENT OR LEGAL GUARDIAN SIGN / ESIGN) (DATE)

ADDITIONAL ADMINISTRATIVE FEES WE CHARGE/BILL TO PATIENT:

1. Letter writing, telephone calls, and/or electronic communications on behalf of patient/client billed at $200/hour after first five minutes.
2. Copying notes, assessments or other legal documents (requires written request) billed at:
   1-20 pages: $1.50 per page, single sided; 21-60 pages: $0.25 per page, single sided
3. Mail: bill/charge for excessive postage costs.

(PATIENT OR LEGAL GUARDIAN SIGN / ESIGN) (DATE)