

# WELCOME TO HERITAGE BEHAVIORAL CENTER

CLIENT'S NAME: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Appointment Time: \_\_\_\_:\_\_\_\_ am pm

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## Your Therapist

\_\_\_\_ C. Jane Morrison, Ph.D., LCSW, LMFT  
\_\_\_\_ Rebecca S. Jones, Ph.D., LCSW, LMFT  
\_\_\_\_ Miles I. Morrison, MSSW, LCSW, SAP  
\_\_\_\_ Jean M. Avery, MA, LPC  
\_\_\_\_ Wayne Crooks, MSW, LCSW  
\_\_\_\_ Judith M. Martin, MEd, LPC  
\_\_\_\_ Kacy S. Flanagan, MS, LPC

\_\_\_\_ Sandra K. Walton, MSW, LCSW  
\_\_\_\_ Patricia Mayo Panther, MSW, LCSW  
\_\_\_\_ Dianne Pipkin, MSSW, LCSW  
\_\_\_\_ Mamoona Hassan, MA, LPC  
\_\_\_\_ Philip A. Edwards, MS, LPC  
\_\_\_\_ Erin T. Frewin, MEd, LPC  
\_\_\_\_ Terri P. Barkley, MEd, LPC, LCDC

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PLEASE.....

1. Complete all attached paperwork in detail.
2. Provide a copy of your driver's license and insurance card.
3. Sign all items and pages as indicated.
4. Provide authorization number from your health plan \_\_\_\_\_
5. Provide number of sessions authorized by your health plan \_\_\_\_\_
6. Your deductible is \$\_\_\_\_\_ and your co-payment is \$\_\_\_\_\_

THANK YOU.

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For Office Use Only: DSM IV TR Axis I: \_\_\_\_\_ GAF: \_\_\_\_\_

Administrative office notes: \_\_\_\_\_

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**NEW PATIENT REGISTRATION**

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient's Name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_

Male Female Single Married Divorced Separated Other

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Social Security Number \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Okay to call? Y N To leave a message? Y N

Office Phone \_\_\_\_\_ Okay to call? Y N To leave a message? Y N

Cell Phone \_\_\_\_\_ Okay to call? Y N To leave a message? Y N

HOW WERE YOU REFERRED TO OUR PRACTICE? \_\_\_\_\_

Person completing this packet \_\_\_\_\_ Rel. to patient \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT \_\_\_\_\_ AT \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_

Male Female Single Married Divorced Separated Other

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Social Security Number \_\_\_\_\_ Email \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Okay to call? Y N To leave a message? Y N

Office Phone \_\_\_\_\_ Okay to call? Y N To leave a message? Y N

Cell Phone \_\_\_\_\_ Okay to call? Y N To leave a message? Y N

**YOUR CLINICAL INFORMATION**

**Why are you seeking therapy today?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous counseling and hospitalizations (when, where, why)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current medications and dosages** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous medications** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**My current physician and phone number** \_\_\_\_\_  
\_\_\_\_\_

**My current psychiatrist and phone number** \_\_\_\_\_  
\_\_\_\_\_

**My current specialist(s) and phone number** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Did you benefit from your previous therapy? (Why or why not)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How did you find out about Heritage Behavioral Center?** \_\_\_\_\_  
\_\_\_\_\_

**Is there anything else we should know about you before your first session begins?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please read and initial all items on lines provided at the end of each statement.

1. If you have no insurance or other health coverage, and prior arrangements have not been approved, our fee for each 45-minute session is \$130. If you are accessing your benefits, your carrier has negotiated the following fees with HBC:

Initial session rate is \$ \_\_\_\_\_ of which your copay is \$ \_\_\_\_\_. The rate for subsequent sessions is \$ \_\_\_\_\_ of which your copay is \$ \_\_\_\_\_. You are also responsible for any annual deductibles as outlined by your insurance benefits plan. Your deductible is \$ \_\_\_\_\_.

NOTE: Some information regarding your benefits has not been received by our business office. Thus, some of the information above could not be itemized.

X \_\_\_\_\_

2. Responsible party for co-payments: If the patient is a child under the age of 18, the parent bringing the child to therapy is responsible for payment prior to the rendering of services.

X \_\_\_\_\_

3. Canceled appointments: If you are unable to honor your appointment, we ask that you cancel at least one business day in advance, so that another patient on our waiting list may be offered that time. If we have not been notified one business day prior, or if the appointment is not kept, you shall be billed the contracted rate (insurance plus co-pay). Your carrier will not pay for late cancels or no-shows, but in most cases, allows HBC to bill you. Employee assistance programs that do not allow HBC to bill in these instances request that we subtract the session from your allotted number of approved sessions.

X \_\_\_\_\_

4. We will file your benefits claims for you, with payment being remitted directly to HBC. Although we make diligent efforts to collect from your carrier, you are ultimately responsible for payment. Any account balances exceeding \$250, or any amount 90 days past due is your responsibility. Additional charges for testing, court testimony, consulting and other services, are not covered by your benefit plan, and are payable in advance.

X \_\_\_\_\_

5. If your HBC clinician is not in your provider network, we will provide you a receipt for your payment so that you may file for reimbursement. It is your responsibility to know if your clinician is in network, by calling the number on your benefits card.

X \_\_\_\_\_

**6. Although information disclosed in sessions is held in strict confidence according to HIPAA regulations, your carrier may require some data in order to process claims.**

X \_\_\_\_\_

**7. Adolescents have a right to confidentiality, which will only be waived if (s)he is in imminent danger. While substance and alcohol usage is serious in nature, and is a focus of treatment, it may not constitute imminent danger.**

X \_\_\_\_\_

**8. Your HBC clinician reserves the right to discontinue treatment if, in the clinician's professional opinion, appropriate progress is not being attained. Upon your request, your clinician will assist you in finding another service provider, or you may contact your benefits carrier for assistance.**

X \_\_\_\_\_

**9. If the patient is a child or adolescent and divorce, separation, custody, or visitation is involved, both parents may be required to sign our standard treatment agreement, and the divorce decree must be submitted to HBC. We do not file with your benefits carrier for court-ordered services. The fee is \$150 per 45-minute session, and is payable prior to the session. In many cases, HBC may require a retainer. All time spent by the clinician is billable.**

X \_\_\_\_\_

**10. Sessions are 45 minutes in length. If you arrive late for the session, it will still end at the scheduled time in order to accommodate other patients. If you arrive more than 15 minutes late, the clinician reserves the right to consider the session as not kept, and may bill accordingly.**

X \_\_\_\_\_

**I, the undersigned patient or responsible party, understand and accept these conditions as written.**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_

Witness \_\_\_\_\_

**INSURANCE AUTHORIZATION AND RELEASE**

I, the undersigned, certify that I, or my dependents, have insurance or employee assistance program benefits in effect with the following carrier: \_\_\_\_\_.

I assign directly to HBC and CJM & RSJ, INC., and/or its clinicians, all related benefits in order to pay for services rendered. Further, I understand that I am financially responsible for any and all debts related to services rendered, whether or not the carrier makes payment. I authorize you to release all information necessary to secure payment. I authorize use of this signature on all claims submissions.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Signature \_\_\_\_\_

**RELEASE of CONFIDENTIAL INFORMATION  
to PRIMARY PHYSICIAN and/or SPECIALISTS**

I hereby authorize HBC and CJM & RSJ, INC., and/or its therapists to disclose to the professionals listed below all clinical data necessary to assure continuity of care, including periodic updates and current health status. This authorization becomes effective \_\_\_\_/\_\_\_\_/\_\_\_\_\_, but may be revoked by me in writing at any time, except to the extent of action already taken. This authorization shall terminate six months after termination of treatment, or upon my written notice to you. I understand that I may request a copy of this release at any time in writing or in person. HIV and AIDS disclosures are not included in this release unless initialed here: \_\_\_\_\_.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Name of professionals covered in this release: \_\_\_\_\_  
\_\_\_\_\_

**OR**

**I DECLINE THIS RELEASE** \_\_\_\_\_

**Continuity of Care  
Information Enclosed Regarding Your Patient  
(FOR CLINICIAN USE ONLY)**

To: \_\_\_\_\_

Fax: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

From: \_\_\_\_\_

**Fax: 972-964-3044**  
**Heritage Behavioral Center**  
**2222 West Spring Creek Parkway**  
**Suite 116**  
**Plano, Texas 75023**  
**Voice: 972-964-3214**  
[heritagecenter@earthlink.net](mailto:heritagecenter@earthlink.net)  
[www.hbcplano.org](http://www.hbcplano.org)

**Re: Your patient, \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_,**  
**was last seen in my office on \_\_\_\_/\_\_\_\_/\_\_\_\_, and has been seen \_\_\_\_ times to**  
**date.**

**DSM IV diagnosis:**      Axis I \_\_\_\_\_ Axis II \_\_\_\_\_ Axis III \_\_\_\_\_  
   Axis IV \_\_\_\_\_ Axis V GAF \_\_\_\_\_

**Current treatment or update:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please contact me with any recommendations or information to enhance ongoing care of  
this patient. Please notify me if you would like periodic updates.**

**Provider Signature:** \_\_\_\_\_

**RECEIPT OF HIPAA INFORMATION**

**I hereby acknowledge receipt of the PRIVACY PRACTICES notification as prescribed by HIPAA.**

**I understand that HIPAA places restrictions on the release of psychotherapy notes to patients or family members. Further, I understand that I may request additional information by contacting the U.S. Department of Health and Human Services at 1-877-696-6775, or by writing the Privacy Officer at Heritage Behavioral Center**

**Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**I am the (circle one, please)      Patient      Parent      Guardian**

**Other:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

## **NOTICE OF PRIVACY PRACTICES:**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal Program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

**TREATMENT** means providing, coordinating, or managing healthcare and related services by one of more healthcare providers. An example of this would include a physical examination.

**PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

**HEALTHCARE OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken such actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy Officer:

**THE RIGHT** to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we disagree to a restriction, we must abide by it unless you agree in writing to remove it.

**THE RIGHT** to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

**NOTICE OF PRIVACY PRACTICES, page two**

**THE RIGHT to inspect and copy your protected health information.**

**THE RIGHT to amend your protected health information.**

**THE RIGHT to receive an accounting of disclosures of protected health information.**

**THE RIGHT to obtain a paper copy of this notice from us upon request.**

**We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.**

**This notice is effective APRIL 14, 2003, and we are required to abide by the terms of the NOTICE OF PRIVACY PRACTICES currently in effect. We reserve the right to change the terms of our NOTICE and to make the new NOTICE provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised NOTICE from this office.**

**You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF CIVIL RIGHTS, about violations of the provisions of this NOTICE or the policies of our office. We will not retaliate against you for filing a complaint.**

**FOR MORE INFORMATION, OR TO FILE A COMPLAINT, CALL OR WRITE:**

**The U.S. Department of Health and Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257 1-877-696-6775**

**OR**

**Miles I. Morrison, LCSW, DCSW, SAP  
Privacy Officer for HBC  
2222 West Spring Creek Parkway, Suite 116  
Plano, Texas 75023  
972-964-3214 phone 972-964-3044 fax  
[heritagecenter@earthlink.net](mailto:heritagecenter@earthlink.net)**