Katie Rhodes, Ph.D., LCSW
Clinical Social Worker

CLIENT REGISTRATION FORM

Please complete the front and back of form, print legibly. Read and sign the form on the back page

CLIENT INFORMATION

CLIENT NAME: ____ DOB:___________AGE:_______

Mailing Address: ____

City: __________________________________ State: _____ Zip Code: ________ E-mail________________

Home Phone: ___________________________ Work Phone:______________ Cell Phone:_____________

Employer's Name:________________________ Occupation: _____________________________________

Marital Status: ___________________________ SS#: ____________________________________

SPOUSE'S NAME: _____________________________________ _______ DOB:___________AGE:_______

Address (if different) ____

City: __________________________________State:_______ Zip: Code____________________

Home Phone: ___________________________ Work Phone: ___________

Employer's Name: ________________________Occupation: ______________________________________

IF CLIENT IS A MINOR:

Mother's Name_______________________________ Father's Name______________________________

DOB: _______________SS#_____________________ DOB: _______________SS#___________________

Address______________________________________ Address_____________________________________

Employer_______________________________ Employer_______________________________

Home Phone: _______________WK#:______________ Home Phone: _______________WK#___________

Is this the custodial parent? Yes No Is this the custodial parent? Yes No

Custodial/Guardian Name, Address, Phone, if different from above:____________________________________

____

EMERGENY CONTACT: Name: ____

Address:____

Home Phone: ____________________Work Phone: __________________ Relationship: _________________

REFERRED BY: Name: _________________________________ Address: ____________________________

BREIF MEDICAL HISTORY

FAMILY PHYSICIAN (PCP):____

Significant Health/Medical Problems: ____

____

Are you currently taking medications? Yes No If yes, please list medication and dosage:

____

____

Any allergies to medication? ____________________ Do you use tobacco products? _____________

PREVIOUS PSYCHIATRIC, PSYCHOLOGICAL, OR PSYCHOTHERAPY TREATMENT

Name of Provider/Facility	City, State	Dates of Treatment	Reasons for Treatment

PLEASE COMPLETE, READ, AND SIGN THE BACK OF THIS FORM

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FINANCIAL ARRANGEMENTS

If you have insurance, I will help your receive maximum benefits. I will contact your insurance company before or during your first visit to verify coverage and benefits. I require that you pay deductible and estimated co-payments before each session. Please allow me to make a copy of your insurance card. I file claims as a courtesy to my clients. Insurance is a contract between you and your insurance company. Under most circumstances, I will not become involved in disputes between you and your insurance company. You are responsible for timely payment of your account.

I GLADLY ACCEPT CASH, CHECKS, OR CHARGE CARDS (MASTER CARD OR VISA)

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company________________	Insurance Company________________
Subscriber's Name ____________DOB______	Subscriber's Name ____________DOB____
Group #__________ID#__________	Group #__________ID#__________
Subscriber #________________	Subscriber #________________
Relationship to Client________________	Relationship to Client________________
Employer________________	Employer________________
Employer's Address________________	Employer's Address________________

PLEASE READ AND SIGN THE FOLLOWING CONSENT

1. I consent to treatment as necessary and desirable to the named client.
2. I agree to read the information titled "Information for My Clients"
3. I understand that regardless of insurance coverage, I am responsible for all charges for treatment or services including additional legal and collection fees required as a result of non-payment. I agree to pay for treatment or services in full at the time of service.
4. I understand that if insurance is filed, my insurance company may ask Dr. Rhodes to provide certain information obtained during my session or treatment (most commonly diagnosis, treatment plans, or treatment methods, though it can be more involved in some instances). I authorize Dr. Rhodes to release any medical or other information necessay to process claims. I also request payment of government benefits to Dr. Rhodes, who accepts assignment
5. I authorize payment of insurance benefits otherwise payable to me, to be paid directly to this provider for the services described on the health insurance claim form, unless other regulations apply.
6. I agree to notify this office immediately of changes in my insurance coverage. If not, I agree to be responsible for fees associated with non-authorized services. I also agree to notify this office of changes in addresses, employment, etc.
7. I understand that Dr. Rhodes requires 24 hour notice if I cancel an appointment. If I fail to cancel an appointment without 24 hour notice, I agree to pay for the time reserved. This charge cannot be billed to my insurance company.
8. I agree to pay 1.5% monthly interest rate (18% APR) on any balance over 60 days which is applied on or about the 25th of each month. Interest will be reflected on statements and covers the cost of billing.
9. There is a $30.00 charge for returned checks. There is a $10.00 fee for re-filing insurance claims.

Client Signature______________________________ Date__________
(if minor client, parent or guardian's signature)

IF YOU HAVE ANY QUESTIONS REGARDING THIS FINANCIAL AGREEMENT, PLEASE DO NOT HESITATE TO SPEAK WITH ME. THANK YOU FOR CHOOSING MY PRACTICE.