

# Patient Registration Form

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_  
Address: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender : \_\_\_\_\_ Marital Status : \_\_\_\_\_  
Parent/Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec # \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_

Do You Have Medical Insurance? Yes No (If Yes, Please Answer ALL Questions Below)

Primary Insurance Company \_\_\_\_\_  
Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Does your insurance require authorization prior to the first session? \_\_\_\_\_ If yes, have you contacted the company? \_\_\_\_\_

Policy Holder's Name & Relationship \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder's Soc. Sec # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Policy Holder's Employer's Name \_\_\_\_\_ Employer's Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer's Address \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Does this insurance require authorization prior to the first session? \_\_\_\_\_ If yes, have you contacted the company? \_\_\_\_\_

Policy Holder's Name & Relationship \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder's Soc. Sec # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Policy Holder's Employer's Name \_\_\_\_\_ Employer's Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer's Address \_\_\_\_\_

## ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my physician to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to my provider, that is otherwise payable to me for his/her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to my provider, will be credited to my account in accordance with the above assignment.

\_\_\_\_\_  
(Print Name of Patient)

\_\_\_\_\_  
(Authorized Signature of Patient/Parent/Guardian)

\_\_\_\_\_  
(Date)

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that you have received a copy of the Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

I have received a copy of the Privacy Notice.  I have had the chance to discuss my concerns and questions about the privacy of my health information.

\_\_\_\_\_  
(Print Name of Patient)

\_\_\_\_\_  
(Authorized Signature of Patient/Parent/Guardian)

\_\_\_\_\_  
(Date)

**Note: If the patient is under the age of 19, their parent or guardian must sign all legal documents provided.**

**Natalie Swift, Psy.D., LMHP**  
**Located at Williamsburg Behavioral Family Psychology Clinic, LLC**  
**Children, Adolescents, Families, Individuals and Couples**

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**CONSENT TO THERAPY AND CONFIDENTIALITY STATEMENT**

In compliance with the ethical and legal guidelines delineated by the American Psychological Association and the American Counseling Association, my counselor has explained that my participation in therapy is completely voluntary and confidential. In signing this document, I provide my voluntary consent to participate in therapy/counseling for myself and/or my minor child. I understand that I may refuse and/or terminate services for myself and/or my minor child at any point during the counseling process, without adverse repercussions between this agency and myself.

I also understand that Natalie Swift, Psy.D., LMHP, will maintain protected health information records relevant to therapy, as well as information obtained through consultation with other professionals. I understand that these records are restricted to the internal use of Natalie Swift, Psy.D., LMHP and their confidentiality will be strictly maintained at all times. I understand that Natalie Swift, Psy.D., LMHP, has employed administrative assistants who manage the transcription, billing, scheduling, filing, and other miscellaneous office duties and that these individuals have been bonded to uphold the state and federal guidelines with regard to maintaining confidentiality. I understand that it may also be shared with a collection agency, should your bill go to collections. Natalie Swift, Psy.D., LMHP, will release the written or verbal information regarding my intake or counseling sessions only upon receipt of my written consent and only to those specified by myself, except in unusual circumstances. In circumstances where there is risk of danger and/or impending harm to myself or others, child abuse, elder abuse and/or certain legal situations (for example, court subpoena of your records), Natalie Swift, Psy.D., LMHP, would be mandated by law to disclose such information for my protection and/or that of others. In such situations, my counselor will make reasonable attempts to discuss the situation with me and enlist my participation in resolving the matter, if possible. If I have any questions, I understand that I can discuss them freely with Natalie Swift, Psy.D., LMHP.

I have had these rights explained to me and by my signature; I indicate my understanding and agreement. I also understand that I have the right to refuse to sign this consent form. By my signature, I authorize that a photocopy or facsimile (FAX) copy shall have the same effect and authority as the original copy of this document.

Client/Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

Children and adolescents may need to discuss information with their counselor in confidence. Often, such information is important for the purposes of providing your child with appropriate assessment and treatment services, but would not be provided to the parent. Natalie Swift, Psy.D., LMHP requests that you support your child's need for privacy, excluding situations in which there is a risk to the health and welfare of your child. I provide my permission to my child's counselor to maintain the confidentiality of my child \_\_\_\_\_, except in circumstances in which there is a risk to her/his health or welfare.

Parent \_\_\_\_\_

**Natalie Swift Psy.D., LMHP**  
**Located at Williamsburg Behavioral Psychology Clinic, LLC**  
**Children, Adolescents, Families, Individuals and Couples**

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**BILLING POLICIES**

The fees for services provided by Natalie Swift, Psy.D., LMHP will be in accordance with the reasonable value set forth by the established community guidelines and standards. At the present time, the fee for the initial 50-minute session is \$200, after which the billing rate for a Psy.D. provider is \$120 per hour for individual therapy, \$140 per hour for family/couples therapy. Clients are expected to pay fees at the time of service unless other billing arrangements are agreed upon in advance. Financial arrangements can be made if client is unable to meet requested fees due to financial hardship. If payment is not received for two consecutive sessions, the client may not schedule an appointment until the fees owed are paid in full. Those clients whom have met their insurance policy's deductible must pay their co-payment per appointment until the insurance benefits are verified. Natalie Swift, Psy.D., LMHP reserves the right to delay, defer, or discontinue services for any reason, including if the balance owed is not paid at the time it is due.

Sessions that are cancelled without notifying Natalie Swift, Psy.D., LMHP prior to 24 hours before the session will be considered late cancellations. A consideration of the client's necessity for counseling will be conducted following the third late cancellation. Should a client discontinue their services with Natalie Swift, Psy.D., LMHP, they are responsible for the payment of any remaining balance for services rendered.

**Cancellations: If you are unable to keep your appointment, please cancel at least 24 hours prior to your appointment time. Failure to do so may result in a \$25.00 fee for No Shows/No Calls and/or Late Cancels.**

I understand that I am liable ultimately for the balance on my account for any services provided by Natalie Swift, Psy.D., LMHP regardless of the status of my insurance situation. With my signature, I agree to adhere to the agency's billing policies and procedures, and to pay any fees that I owe the agency based upon such policies. I hereby authorize direct payment and all benefits due under my insurance policy to, Natalie Swift, Psy.D., LMHP for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims. I also authorize the release of medical or other protected health information necessary to collect unpaid bills (i.e., forward to a collection agency).

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

Signature \_\_\_\_\_

Date: \_\_\_\_\_

**Natalie Swift, Psy.D., LMHP**  
**Children, Adolescents, Families, Adults, Individuals and Couples**

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**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

I, \_\_\_\_\_  
Name of Patient

Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Birth Date \_\_\_\_\_

**Hereby Authorize:**

Natalie Swift, Psy.D., LMHP  
LOCATED AT WILIAMSBURG BEHAVIORAL PSYCHOLOGY Clinic, LLC  
3801 UNION DRIVE, SUITE 206, LINCOLN, NEBRASKA 68516

\_\_\_\_\_ To Receive Protected Health Information From: \_\_\_\_\_ To Release Protected Health Information To:

\_\_\_\_\_  
Name of Health Care Provider/Agency/Plan/Other

Street Address \_\_\_\_\_ City, State Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

**INFORMATION TO BE RECEIVED:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Medical History, Examination, Reports | <input type="checkbox"/> Social History      | <input type="checkbox"/> Academic Records             |
| <input type="checkbox"/> Psychological Evaluation              | <input type="checkbox"/> Treatment Plan      | <input type="checkbox"/> Consultations                |
| <input type="checkbox"/> Psychiatric Evaluation                | <input type="checkbox"/> Termination Summary | <input type="checkbox"/> Hospital Records and Reports |
| <input type="checkbox"/> Laboratory Reports                    | <input type="checkbox"/> Prescriptions       | <input type="checkbox"/> Entire Record                |
| <input type="checkbox"/> Other (Specify): _____                |  |   |

**SUCH INFORMATION WILL BE USED FOR THE PURPOSES OF:** (Check applicable categories)

- |   |   |   |                                    |
|---|---|---|------------------------------------|
| <input type="checkbox"/> Evaluation and/or Treatment    | <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Legal Investigation or Action        | <input type="checkbox"/> Follow up |
| <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Changing Physicians  | <input type="checkbox"/> Educational Planning and Programming | <input type="checkbox"/> Personal  |
| <input type="checkbox"/> Other (Specify): _____         |   |   |                                    |

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to Inspect or Copy the Health Information to Be Used or Disclosed**

- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contact Natalie Swift, Psy.D., LMHP. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: Natalie Swift, Psy.D., LMHP. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

**Expiration Date:** This authorization is good until the following date(s) \_\_\_\_\_ or for 12 months from the date signed.

**I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes and I am releasing, Natalie Swift, Psy.D., LMHP from all liability resulting from this disclosure. By my signature, I authorize that a photocopy or facsimile (FAX) copy shall have the same effect and authority as the original copy.**

**Signature of Patient or Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(If signed by other than patient, state relationship and authority to do so.):S:*

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