

# 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.

\_\_\_\_\_  
(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.*

## Consent Form and Confidentiality Statement

In compliance with the ethical and legal guidelines delineated by the American Psychological Association, I understand that my participation in assessment/therapy is completely voluntary and confidential. In signing this document, I provide my voluntary consent to participate in assessment/therapy 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 assessment/therapy process, without adverse repercussions between this agency and myself.

I also understand that Dr. Nancy Mize, Ph.D. will maintain protected health information records relevant to assessment/therapy, as well as information obtained through consultation with other professionals. I understand that these records are restricted to the internal use of and their Dr. Nancy Mize, Ph.D. confidentiality will be strictly maintained at all times. I understand that Dr. Nancy Mize, Ph.D. through Williamsburg Behavioral Psychology, LLC, has employed administrative assistants who manage the transcription, billing, scheduling, filing, and other miscellaneous office duties as well as clinical interns to support the assessment and therapy process, and that these individuals have been bonded to uphold the state and federal guidelines with regard to maintaining confidentiality. Dr. Nancy Mize, Ph.D. will release the written or verbal information regarding my 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, abuse of a child or vulnerable adult, and/or certain legal situations (for example, court subpoena of records), Dr. Nancy Mize, Ph.D., would be mandated by law to disclose such information for my protection and/or that of others. In such situations, my therapist 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 Dr. Nancy Mize, Ph.D. or a member of her staff.

By signing, I indicate my understanding and agreement with the above information and I consent to psychological services for myself or my minor child. 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. Dr. Nancy Mize, Ph.D. 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 \_\_\_\_\_

# Billing Policies and Information

The fees for services provided by Dr. Nancy Mize. Ph.D. will be in accordance with the reasonable value set forth by the established community guidelines and standards. Here is a list of some, but not all, of the services that provides. Dr. Nancy Mize. Ph.D. In parentheses are the rates as of August of 2016, although rates are subject to change. *Please be aware that not all services are covered by every insurance company, and you will be responsible for the remaining bill.* Patients are expected to pay fees at the time of service unless other billing arrangements are agreed upon in advance. Copayments are expected at each session. If a patient is unable to make on-time payments, the patient may be referred to an alternative provider. Dr. Nancy Mize. Ph.D. 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.

CPT Code	Cost	Description
90791	\$245	Initial Session
90832, 90834, 90837	\$110, \$160, \$245	Individual therapy, vary by session length
90846/90847	\$170/\$180	Family therapy
90839	\$245	Crisis Psychotherapy
90853	\$40	Group therapy
90887	\$80	Feedback session, per 15 minutes
90889	\$80	Preparation of documentation (e.g., for another agency, attorney, court, school)
98966, 98967, 98968	\$40, \$60, \$80	Phone calls with a therapist or psychologist, vary by length (5-30 minutes) *May include provider contact with patient, parent, school, attorney, etc.
98969	\$40	Email or some other online contact with a therapist or psychologist
96101 and 96118	\$140 & \$160	Psychological Assessment Services

### Electronic Communication Policy

It is expected that all non-emergent contact with your provider will take place during a scheduled session. As such, regular communication via phone, email, or other electronic means is not typically utilized. If an emergent situation arises, please contact the office to get a message to your provider and schedule an appointment as soon as possible, or call the crisis line. On occasion, patients may still choose to email their provider. By signing, you recognize that while your provider utilizes a secure email provider, confidentiality of any information sent online cannot be guaranteed.

### No Show and Late Cancellation Policy

We are sincerely dedicated in assisting you with meeting your goals. Consistent attendance allows for quicker recovery and better outcomes. However, if you are unable to keep your appointment, *please cancel 24 hours prior to your appointment time* and we will be happy to reschedule your visit. Other patients who can be seen during the appointment time will be grateful for your thoughtfulness as well.

You may be charged \$35 for a therapy appointment or \$70 for an assessment appointment if you do not show or cancel less than 24 hours before your appointment time. Your insurance does not cover charges for late cancellations or no-shows. We understand that unavoidable situations occasionally arise when an appointment cannot be kept and adequate notice is not possible. In the case of an emergency, the fee may be waived on one occasion.

I understand that I am ultimately liable for the balance on my account for any services provided by Dr. Nancy Mize. Ph.D. regardless of the status of my insurance situation. With my signature, I agree to adhere to the billing policies and procedures, and to pay any fees that I owe Dr. Nancy Mize. Ph.D. based upon such policies. I hereby authorize direct payment and all benefits due under my insurance policy to Dr. Nancy Mize. Ph.D. for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Authorization for Release of Information

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

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

**Hereby Authorize:**

Dr. Nancy Mize. Ph.D.  
3801 Union Drive Ste 206  
Lincoln, Nebraska, 68516

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

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

Street Address (Include City, State, Zip Code) \_\_\_\_\_ Fax 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"/> Supervision and/or Consultation	<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 contacting **Dr. Nancy Mize. Ph.D.** **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: **Dr. Nancy Mize. Ph.D.** 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 one year 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 Dr. Nancy Mize. Ph.D. 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.)

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