Registration Form
Psychology Consultation Specialists

Date_____

Patient Information

Patient Name (Print) _____ **Date of Birth** _____
Last Name First Name Initial

Street Address:_____ City: _____ State: _____ Zip:_____

Home/Cell: _____ Messages okay? Y N **Work**: _____ Messages okay: Y N

Email address: _____

Emergency Contact Name / Phone Number: _____

Gender: Female Male **Marital Status:** Single Married Widowed Divorced Separated Other

Employer_____**Occupation** _____

Primary Insurance

Primary Insurance Company_____Phone: _____

Ins Claims Address _____City:_____State:_____Zip: _____

Policy/ID #_____Group/Plan#: _____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name:_____Relationship: _____
Last Name First Name Initial

Address:_____ City:_____State:_____Zip: _____

Soc. Sec#:_____Employer:_____**Date of Birth:** _____
REQUIRED

Secondary Insurance

Secondary Insurance Company _____ Phone: _____

Ins Claims Address _____City:_____State:_____Zip: _____

Policy/ID #_____Group/Plan#: _____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name:_____ Relationship: _____
Last Name First Name Initial

Address_____ City:_____ State:_____ Zip: _____

Soc. Sec#:_____ Employer:_____ **Date of Birth:** _____
REQUIRED

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____
Responsible Party Signature Relationship Date

info@pcsmn.com
www.pcsmn.com

PSYCHOLOGY CONSULTATION SPECIALISTS PLLC
CHILD | TEEN | FAMILY | ADULT

763.559.7050
3300 Fernbrook Lane N, #120
Plymouth, MN 55447

Please read this policy carefully, initial where indicated and sign.

Consent to Treat

- Psychological services include consultation services regarding behavioral, developmental, or emotional concerns; which provides diagnostic clarification and treatment recommendations, and psychotherapy; which has been shown to have benefits in the reduction of feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees or assurances of what you will experience.
- Providers are often not immediately available by telephone. A message may be left with the front desk or on the provider's confidential voicemail. Every effort to return your call within a reasonable time is made during business hours. In the event of an emergency, contact your family physician, call 9-1-1 or proceed to the nearest emergency room.

Assignment of Benefits / Payment for Services

- There is a standard fee for professional services. Please ask for a fee schedule for details.
- Insurance will be billed for services. Insurance may or may not cover the services provided at Psychology Consultation Specialists. You are responsible for the amount due for any services not covered by your insurance plan. Payment can be made with a check, cash, or credit card. I understand that I am financially responsible for all charges. _____ (initial)
- Insurance companies require a formal diagnosis with their claims. Diagnoses are technical terms that describe presenting concerns.
- Any checks returned to the office are subject to an additional fee of $25.00.
- Past due accounts more than 60 days will be turned over to a collection service or small-claims court.
- Psychology Consultation Specialists (PCS) will bill your insurance company for your appointments. If you do not pay your deductible, co-pay, or co-insurance at the time of your appointment, PCS will send you a billing statement. Any statement amount that you do not pay in full via the due date of that statement will be charged to the credit card on file. It is our office policy to have a credit card number on file.
- If your account is sent to collections for non-payment, there will be a 33.33% fee added to the outstanding balance to cover incident collections costs.

Important Notes

- CANCELLATION POLICY: Cancellations made with less than 24 hours' notice will be charged the full appointment fee ($200.00 - $250.00 / hour). This charge cannot be billed to your insurance policy. _____(initial)
- Financial arrangements between divorced parents must be handled independently of Psychology Consultation Specialists. Although court orders may assign responsibility for a child's healthcare expenses to one parent or another, we, as mental health providers, are not bound by the terms of such court orders. Fees due on the day of an appointment must be collected at every visit regardless of who brings a child to the appointment. _____(initial if applicable)
- If you become involved in litigation that requires Psychology Consultation Specialists participation (it is recommended that this is discussed fully *before* waiving the right to confidentiality), you will be responsible for the payment of professional time required even if Psychology Consultation Specialists is compelled to testify by another party. Our charge is $315.00 per hour for preparation and attendance at any legal proceeding.

By signing this consent for treatment, you fully understand the office policies and agree to abide by them. You acknowledge that you have been provided with a copy of the Notice of Privacy Practices, which describes uses, disclosures, and rights of your protected health information.

_____ _____ _____ _____

(Signature of Patient) Date (Signature of consenting party, if other than patient) Date

_____

(Relationship to patient)

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ADULT HISTORY FORM

I. General Information

Date_____

Name/DOB: _____ Preferred Name: _____

Reason for referral; what are your primary concerns?

_____

_____

_____

Level of Education: _____ Occupation: _____ Employer: _____

You are: _____ Married ___ Never Married ___ Separated ___ Divorced ___ Living together ___ Other_____

Please list all individuals in the home:

Name	Relationship	Age

Has you experienced neglect or abuse? Yes _____ No _____ Suspected _____ Unknown _____

Have you ever lost someone with whom you had a close relationship, (e.g. a parent, sibling, etc.)?

_____

Have there been any recent stressful life events? (check all that apply)

	Divorce/Separation		Financial Problems		Substance Abuse
	Death of Family/Friend/Pet		Marriage		Change in Job Status
	Disagreement about parenting		Relationship conflict		Sibling conflict
	Other: _____				

II. Medical History

Have you ever had any of the following (check all that apply):

		Age			Age
	Meningitis			Loss of consciousness	
	Head injuries/Concussions			High fever	
	Ear infections			Heart Disease	
	Asthma			Seizures	
	Other Illness:			Other Illness:	

Please describe treatment given and any complications for illnesses/injuries indicated above:

_____

_____

Have you ever been hospitalized?_____ At what age:_____ For what: _____

Describe any hearing or vision problems:_____

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List any previous surgeries, age, and length of hospitalization:_____

_____

Other medical history: _____

Does you frequently complain of or have problems with (check all that apply):

	Headache		Weakness		Fatigue
	Dizziness		Nausea		Wetting/soiling accidents
	Stomach aches		Diarrhea		Muscle tension

Current Medications: _____

For what has this medication been prescribed? _____ Side Effects:_____

Who prescribes this medication? _____

Previous medications & dates taken:_____

Family Medical History: Has anyone in your family had any of the following?

	Yes	Who	Explain
Neurological Disease			
Seizures (Epilepsy)			
Psychiatric Problems			
Emotional Problems			
Alcoholism Problems			
Substance Abuse Problems			
Language Delays			
Motor (physical) Delays			
Hyperactivity			
Learning Problems			
Autism Spectrum Disorders			
Similar problems to you			

III. Evaluations & Services

For each category, please list any previous evaluations, examiners, dates, and results.

Health:

Primary Doctor:_____

Telephone: _____ Fax: _____

Psychological/Neuropsychological:

Therapist/Examiner's Name: _____ Title: _____

Telephone:_____ Fax: _____

Dates of Last Evaluation/Sessions: _____

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Occupational Therapy/ Physical Therapy/Speech & Language Therapy:

Date of Evaluation: _____

Clinic Name & Examiner's Name: _____

Therapy: Dates attended _____

Vision/Hearing:
Date of Last Examination: _____

Neurological:
Neurologist's Name: _____

Date of Last Examination: _____

Other: _____

_____