Patient Registration

Patient (for children complete the applicable sections)

Patient Name _____ Former Name _____ Birth Date: / / Age _____

Gender/Identity: ☐ Male ☐ Female - Marital Status: ☐ Single ☐ Domestic Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Mailing Address _____ City _____ State _____ Zip Code _____

Physical Address _____ City _____ State _____ Zip Code _____

Employer _____ Work Phone _____ Home Phone _____

Cell Phone _____ **SSN** _____ Driver's License _____ Education/**Grade** _____

Party responsible (not the insurance company) for payment; if different than the patient

Name _____ Relationship to Patient _____ Birth Date / /

Mailing Address (if different from above) _____ SSN _____

Employer _____ Driver's License _____

Cell Phone _____ Home Phone _____ Work Phone _____

THE FOLLOWING SECTION MUST BE COMPLETED (Provide all known information)

Parent(s) or Legal Guardian(s)

Name _____ Relationship _____ Birth Date / /

Home Address (if different from above) _____ Home/Cell Phone _____

Employer _____ SSN _____

Driver's License _____ Work Phone _____ Email_____

Co-Parent(s) or Co-Legal Guardians(s)

Name _____ Relationship _____ Birth Date / /

Home Address (if different from above) _____ Home/Cell Phone _____

Employer _____ SSN _____

Driver's License _____ Work Phone _____ Email_____

I hereby authorize Tyler Counseling & Assessment Center (hereafter referred to as TCAC), and its associates to furnish information to insurance carriers concerning my treatment on the date services are rendered and I hereby assign to TCAC, and its associates all payments for all services rendered. By signing this form, I acknowledge and understand that I am responsible for all co-pays and co-insurance payments and any amounts not covered by insurance for services rendered on the date of service. I accept financial responsibility to pay all balances billed to insurance which remain unpaid for any reason by the carrier within 8 weeks of the date of billing. I understand that insurance certification or approval for a service does not guarantee payment as per Texas Dept. of Insurance rules and regulations. Additionally, the failure to provide TCAC with current insurance information will result in my liability for payment of all services rendered. A returned check fee of $55.00 will be charged in addition to any applicable banking fees on all returned checks. Checks must be dated for the date services are rendered. For your convenience, we accept VISA, MasterCard, AMEX, and Discover Card. Our office will be happy to submit claims to your insurance company.

Signature of Responsible Person _____ Relationship _____ Date _____

BRIEF HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Previous or referring doctor:	Date of Last Exam:

PERSONAL HEALTH HISTORY			
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			
Name the Drug	Reason	Strength/Frequency Taken	

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	☐ Yes	☐ No
	Have you considered stopping?	☐ Yes	☐ No
	Have you ever experienced blackouts?	☐ Yes	☐ No
	Are you prone to "binge" drinking?	☐ Yes	☐ No
	Do you drive after drinking?	☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Previous Counselor/Psychologist Name: _____ Date of Last Visit: _____

What was the reason for past counseling?

_____

Have you ever been hospitalized for mental health reasons or a suicide attempt? ☐ Yes ☐ No If Yes, when: _____

Have you ever discontinued medical/psychiatric care Against Medical Advice? ☐ Yes ☐ No

Informed Consent & Patient Contract

Staff and Ownership Disclosure

Tyler Counseling & Assessment Center, hereby referred to as TCAC, is staffed by independent/non-employee mental health providers who are fully licensed to perform mental health services in the State of Texas, within the scope of their individual license. Your provider's licensure information is available upon request. The contact information for the applicable State licensing board may be obtained from the front desk. TCAC is owned by Ron L. Roberts, M.S., P.C., a professional corporation licensed to do business as Tyler Counseling & Assessment Center.

Counseling (Individual, Child Therapy, Marriage/Family Therapy) & Assessment (to include cognitive, academic, psychological testing, adaptive functioning)

Counseling is a collaborative process between you and your provider where mental health stressors and disorders are evaluated, assessed, and treated. For therapy to be most effective, it is essential that you take an active role in the process. The counseling process may open levels of awareness and provoke realizations that may cause uncomfortable feelings. In some cases, major life decisions are made, in others traumatic events are reflected upon. This process of growth can cause significant impacts to lifestyles, and relationships. We strive to provide the highest quality mental health services. However, the limitations on our provider's ability to provide care are often affected by insurance and/or managed care providers. Such issues may affect the content and outcome of counseling. Assessments are often performed to determine cognitive functioning, academic strengths and weakness, as well as current psychological and adaptive functioning.

Appointments

Sessions are generally scheduled in 45-minute increments (Insurance companies allow a 35-53-minute session), with sessions scheduled at the frequency recommended by the provider based on your individual circumstances and needs. Clients are responsible for scheduling appointments in advance. Some situations may justify modification of the schedule, thus increasing or decreasing frequency of appointments. If you need to cancel an appointment, please contact us at 903-581-0933 at least 24 hours in advance. Cancellations with less than 24 hours notice will be charged a **$90 no-show or late cancel fee**. We reserve the right to terminate the relationship if 2 consecutive appointments are missed without notification and payment of no-show fees is not made. Your insurance company will not pay for missed appointments.

Fees and Payment

Co-payments with approved insurance, or payment in full, will be collected at the time the service is rendered. The first visit with your provider is $115.00. The customary fee for 45 to 50-minute sessions are $95.00. Family Therapy sessions are provided by qualified providers at the rate of $130.00 per session. Educational testing fees are not billed to insurance and are performed on a cash basis. Assessment fees vary widely and should be discussed with your provider.

Fees will be charged for certain testing supplies, as well as written reports, telephone consultations lasting longer than 10 minutes, attendance at meetings with other professionals, preparation of records or treatment summaries, and the time spent performing any additional service you may request of your provider. **TCAC will not act as a mediator regarding parent financial responsibilities. The parent authorizing treatment of a minor child is responsible for payment at the time services are rendered regardless of divorce/custody agreements or orders.**

Concerning Child Custody

Your provider is ethically and legally bound by Licensing Regulations and the Texas Family Law Code NOT to give an opinion about a parent's custody, visitation suitability, or access to a child without having performed a custody evaluation of all involved parties. Our providers will not accept court appointments in proceedings involving suits affecting the parent-child relationship or divorce. If the court appoints a custody evaluator, guardian ad litem, or

parenting coordinator, your provider will provide this professional with information as needed (with appropriate releases/authorizations). However, the provider will not make any recommendation about the final decision. If your provider is required to appear as a witness, you are responsible for the payment of the provider's professional time at the rate of $250.00 per hour for traveling, preparing reports, testifying, being in attendance, and any other case-related time. A $750.00 per half-day and $1,500.00 per full-day court deposit will be required BEFORE any hearing or court proceedings. **If these fees are not received prior to 48 hours of the court proceeding the request for appearance will be considered void.** Refunds of court related deposits will not be made until proof of the disposition or completion of your legal proceedings are provided. **NO MINOR WILL BE SEEN FOR TREATMENT OR ASSESSMENT WITHOUT THIS OFFICE RECEIVING A COPY OF THE MOST RECENT COURT DOCUMENTS RELATED TO CUSTODY OR TEMPORARY ORDERS. UNLESS STATED BY COURT ORDER YOUR CHILD'S PROVIDER DOES HAVE A RESPONSIBILTY TO NOTIFIY THE CO-PARENT OF YOUR CHILD'S TREATMENT AND MAY INVITE THE CO-PARENT TO PARTICIPATE.**

Records

We are required by law to maintain detailed records each time we interact. Mental Health records contain sensitive information including observational data, diagnosis, treatment plans, and other clinically relevant information. During treatment, information may be provided to insurance companies, managed care companies, other healthcare providers, and/or courts. We will release records, in full or in part, with you as the patient if requested; unless the determination is made that such a release may hinder progress or otherwise cause undue harm. Certain types of records, test protocols, and questionnaires are protected by copyright, trade secret laws, or other State or Federal regulations and may not be released. Except for third-party payors such as insurance companies or Social Security disability applicants the clinic charges a minimum fee of $6.50 or each record for the first 25 pages. Postage in excess of the current standard letter rate will also be assessed.

Termination

You may expect that the patient client relationship will be terminated when you have received maximum benefit from your counseling or have achieved the desired goals. Patients who miss appointments and do not reschedule or call to confirm their next appointment will be deemed to have terminated their counseling relationship after 30 days.

Emergencies

We engage a medical answering service to answer after hour calls (**903-581-0933**). However, if a provider is not immediately available, please contact 911 or proceed to the nearest emergency room for evaluation. The answering service is only authorized to contact on-call provider in the case of an emergency. The on-call provider cannot provide medical advice or treatment for conditions outside of their licensure or expertise.

Emergency Contact

I hereby give TCAC and my provider permission to contact the following individual(s) in the event of an emergency:

Contact Name_____Relationship_____Phone _____

Contact Name_____Relationship_____Phone _____

I have read, understood, agree, and consent to the above conditions of service. I have had the opportunity ask questions regarding the above policies. Failing to read before signing this document does not void this contract.

Patient/Guardian Signature_____Date_____

Co-parent/Guardian Signature_____ Date_____

TYLER COUNSELING & ASSESSMENT CENTER

1 1 21 E. SOUTHEAST LOOP 323 - SUITE 204 - TYLER, TX 75701

CONSENT FOR TREATMENT OF A MINOR

We/I, the undersigned parent(s), legal conservator(s) and/or guardian(s) of the minor child (Child's Name) _____,, hereby gives the contracted provider with Tyler Counseling & Assessment Center authority to proceed with a clinical evaluation and treatment as the contracted provider's professional judgment indicates.

This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal authority to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that Tyler Counseling & Assessment Center and the contracted provider is hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that the contracted provider's duties are performed within professional standards of care and responsibility; to the best of the contract provider's professional ability. We/I retain the right to retract this consent at any time after consultation with the child's contracted provider.

I, _____,understand that Tyler Counseling & Assessment Center believes that it is in the best interest of children being raised between two or more homes to have both parents involved in therapy when possible unless prohibited by a court order (or if a biological parent has legally surrendered parental rights and has no contact with the child/documentation must be provided). I hereby consent for Tyler Counseling & Assessment Center to contact my co-parent and invite them to attend an intake interview or therapy sessions at the discretion of the counselor. I understand that ifl decline to allow Tyler Counseling & Assessment Center to contact and invite my co-parent to therapy sessions, my child may be discharged from care and referred to another clinic for future needs. The most recent court orders or temporary orders affecting the parent-child relationship must always be provided to this office by the consenting parent(s) or guardian(s).

Signed this day of_____ of_____,, 2_ _

_____ _____

Parent or Guardian Signature | Printed Name

_____ _____

Co-Parent or Co-Guardian Signature | Printed Name

If this form is completed by only one parent or guardian, please provide the following information regarding the child's other parent(s) or guardian(s):

Last Name	First	Middle	☐ Mr.	☐ Ms.		Marital Status (Circle One) Single / Married / Other
Street Address	City	State	ZIP Code	Soc al Se urity		Home Phone No. ( )
P.O. Box	City	State	ZIP Code			Cell Phone No. ( )
Occupation	Employer					Work Phone No. ( )

NOTICE OF PRIVACY PRACTICES

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

Tyler Counseling & Assessment Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at Tyler Counseling & Assessment Center, please contact:

Ron L. Roberts, M.S., P.C., Clinical Director, **Tyler Counseling & Assessment Center**, 1121 ESE Loop 323, Suite 204, Tyler, Texas 75701, Phone: 903-581-0933 – Fax: 903-581-3977.

Understanding Your Health Record/Information

Each time you visit Tyler Counseling & Assessment Center a record of your visit is made. Typically, this record contains your symptoms, progress and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a source of data for facility planning and marketing and
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Tyler Counseling & Assessment Center the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health r cord as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and. privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by a provider (e.g.: counselor, psychiatrist, or psychologist) will be recorded in your record and used to determine the course of treatment that should work best for you. Your provider will document in your record his expectations and your progress. Your provider will then record the actions they took and their observations. In that way the provider will know how you are responding to treatment. We will also provide your physician or a

subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this clinic. *We will use your health information for payment. For example:* A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used, *we will use your health information for regular health operations. For example:* The clinical director and those designated by him may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used to continually improve the quality and effectiveness of the healthcare and service we provide.

Other Uses or Disclosures

Business Associates: Most services provided in our organization are provided through contracts with business associates. All providers in this clinic are independently contracted with our clinic and are non-employees (this includes all mental health providers as well as answering service personnel). When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Fax & Cellular Communications: Tyler Counseling & Assessment Center and its business associates utilizes fax telecommunication devices and cellular telephones in our regular course of business. While every care will be taken to protect your privacy; cell phones and fax transmissions are not strictly private forms of communication. We have determined in the interest of providing you with timely access to services and information that the risk to your privacy in the use of these devices is an acceptable risk.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition in cases of emergency to be determined by your provider and the clinical director.

Communication with Family. Except in the case of emergencies to be determined by your provider and the clinical director; no information will be released to your family members without your express written consent.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: 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.

Food and Drog Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

My signature below acknowledges that I have read and consented to the Notice of Privacy Rights as adopted by this office January 2003 and January 2020.

_____ _____

Signature of Patient or Legal Guardian Date

If signed by Legal Guardian, relationship to the patient: _____