Patient Registration Information

Patient's Name

First | Middle | Last

Patient's Gender

○ Man ○ Woman

⦿

Patient's Date of Birth

Home Phone

Cell/Work Phone

May we leave a message on your Home Phone?

○ Yes ○ No

May we leave a message on your Cell Phone?

○ Yes ○ No

Address

Address Line 1

Address Line 2

City | State | Zip Code

Parent/Guardian's Name (If Applicable)

First | Middle | Last

Parent/Guardian's Cell/Work Phone (If Applicable)

Parent/Guardian's Email (If Applicable)

In Case of Emergency, Please Contact:

First

Last

Emergency Contact's Relationship to Patient

Emergency Contact Phone Number

Chose Clinic Because/Referred to Clinic by (Please choose one)

○ Doctor ○ Insurance Plan ○ Hospital ○ Family/Friend ○ Convenient Location ○ Found on Google or Social Media

⦿

Payment (Choose One)

○ I will pay for these services directly and do not wish to have you bill my insurance.

○ Please bill my insurance using the information provided on the next page.

Insurance Information

Only complete this form if you are planning on filing through insurance. Otherwise, please skip to the next page.

Patient Name:

Patient's Social Security Number

Primary Insurance Name:

E.g. BCBC, Aetna, etc

Subscriber (Policy Holder)'s Date of Birth

Name of Subscriber (Policy Holder)

First

Last

Patient's Relationship to Subscriber

○ Self ○ Spouse ○ Child

⦿

ID or Policy Number

Group Number

Occupation of Subscriber

Subscriber's Employer

Employer's Address

Address Line 1

Address Line 2

City

State

Zip Code

Employer's Phone

Secondary Insurance Name

Name of Insured

Patient's Relationship to Subscriber

○ Self ○ Spouse ○ Child

First

Last

ID or Policy Number

Group Number

(Initials) I authorize Mission Psychology and the above insurance provider(s) to release any information required to process my claims.

Authorization of Treatment and Payment

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Mission Psychology. I understand that I am financially responsible for any balance.

Signature

Date

Name of Responsible Party

First

Last

Cancellation Policy

Failure to cancel an appointment within 24 hours of the scheduled time is considered a "No-Show" and is billed at the full rate. I understand that insurance usually does not pay for no-shows, and I will be responsible for the fee myself.

Initials

Notice of Receipt of Policy Regarding Protected Health Information

Please sign below to indicate that you have been given the opportunity to review Mission Psychology's policies regarding protected health information. If you request it, we will provide you with a paper copy of the policy.

Name

First

Last

Signature

Date

Credit Card Authorization

We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable, including, but not limited to, copayments, coinsurance, any amount applied to your deductible, no show appointment fees, and other billing charges. If you have any questions or concerns about this policy, please discuss with your clinician before signing.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to your account.

I authorize Mission Psychology to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Card Type

⦿ Visa ○ Mastercard ○ Discover

Credit Card Number

Expiration Date

3-Digit Security Code

Cardholder Name

First

Last

Billing Address

Address Line 1

Address Line 2

City

State

Zip Code

Signature

I, the undersigned, authorize and request Mission Psychology to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Mission Psychology. This authorization will remain in effect until I cancel this authorization. To cancel, I must give 60 day notification to Mission Psychology in writing and the account must be in good standing.

Patient Name

First

Last

Responsible Party Name

First | Last

Responsible Party Signature

Date

Therapy Questionnaire

Please fill out the following questions with as much detail as you can. You may wish to ask family or friends to help you remember details before your appointment.

Who is filling out this questionnaire?

○ Self

⦿ ______

Who do you live with? (Check all that apply)

☐ Parent(s) ☐ Child(ren) ☐ Spouse ☐ Friend ☐ Relative
☐ Alone

How long have you lived in the current place?

______

Family and Social History

Who raised you?

☐ Biological Parents ☐ Adoptive Parents ☐ Foster Parents ☐ Step-Parents

☐ ______

At what age did you become independent?

______

Describe your caretakers (type of work, personality, etc.)

______

Where did you grow up?

______

When growing up, how many siblings did you have?

______

List their names and current ages:

What type of relationship did you have with your parents?

What type of relationship did you have with your siblings?

How was your social adjustment growing up?

○ Very good ○ Good ○ Average ○ Marginal ○ Poor

What extracurricular activities did you participate in while growing up?

What social activities did you participate in while growing up? (i.e. Dating, friends, hobbies)

Education History

What level of education did you complete?

○ Some high school ○ Graduated high school ○ Some college or vocational training ○ Graduated college

⦿

Average grades?

○ Very Good ○ Good ○ Average ○ Marginal ○ Poor

Did you repeat any grades?

○ Yes ○ No

Describe any discipline problems in school (i.e. suspensions, police intervention, etc.)

Describe any special educational services, classes, or accommodations, or other help you were given in class or testing.

Legal History

Current and Past Substance Use (i.e. alcohol, marijuana, prescription drugs, etc.)

Substance	Age Started	Last Used	Frequency of	Problems	Treatment

			Use	Caused	

Past criminal charges (i.e. reckless driving, DWI, theft, assault, etc.)

Legal Charge	Date	Result (incarceration, parole, etc.)

Describe any history of violence, fights, or assaults:

Work History

Are you currently employed?
○ Yes ○ No

Describe any times in the past 12 months that your mental/emotional complaints caused you to miss work:

Previous Work History

Position	Start Date	Duration	Fired?	Reason for Leaving
			No	

Military History

Please list branch of service and start and stop dates:

Relationship History

Current Marital Status
☐ Married ☐ Divorced ☐ Separated ☐ Live with Partner, but Not Married
☐

Describe your current relationship:

Past Marital History

Start Date	Duration	# of Children	Reason for End of Marriage

Do you have children?
○ Yes ○ No

Who do you spend the most time with (i.e. spouse, family, friends, etc.)?

Describe your current social interaction and level of satisfaction with it?

How do you feel others in your life view you?

What are your hobbies or favorite past-times?

Medical History

Do you experience chronic pain?
○ Yes ○ No

List any serious medical problems, surgeries, etc. (Start with most recent)

Illness	Date Treated	Current Meds	Length of Hospitalization?

History of Psychiatric Care (inpatient, outpatient, etc)

Problem	Start Date	Current Meds	Counseling or Treatment?

Have you ever attempted suicide?
○ Yes ○ No

Please describe any family history of psychiatric problems:

Other Information

What else would you like for me to know?

What have you tried so far that has helped or not helped?

What are your goals for treatment?

Preparing for Change

Please rate the following (1 = Not Ready, 10 = Very Ready)

	1	2	3	4	5	6	7	8	9	10
Your readiness for change	○	○	○	○	○	○	○	○	○	○
Challenge of changes needed	○	○	○	○	○	○	○	○	○	○
Your capability to meet those challenges	○	○	○	○	○	○	○	○	○	○