North Hills Psychological Associates, Inc.

REGISTRATION FORM

(Please Print)

CLIENT INFORMATION

Client's Last name: First: Middle:	Age:	DOB:	Gender associated with insurance: ❑ M ❑ F	Marital status: Single Married Div. Div. Sep. W.

Home phone #: OK to leave message? Yes No	Mobile phone #: OK to leave message? Yes No	Work phone #: OK to leave message? Yes No

Street address:

P.O. Box:	City:	State:	ZIP Code:

How did you hear about us? (please check one box): ❑ Dr. ❑ Insurance ❑ Hospital ❑ Family ❑ Friend

❑ Close to home/work ❑ Yellow Pages ❑ Internet ❑ Other _____

Whom may we thank for referring you?

I give my permission for the following friend or relative to be called in case of emergency:	Relationship to Client:	Home phone #:	Mobile phone #:

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist.)

Name of primary insurance:

Subscriber's name:	Subscriber's SS#:	Subscriber's DOB:	Group #:	Policy ID#:

Employer:	Employer address:

Client's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Is Client covered by secondary insurance? ❑ Yes ❑ No	Name of secondary insurance:

Secondary Subscriber's name:	Subscriber's SS#:	Subscriber's DOB:	Group #:	Policy #:

Employer:	Employer address:

Client's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

AGREEMENT AND RELEASE

I assign directly to NHPA, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any balance owed and all services not covered by my insurance. I hereby authorize NHPA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I will keep NHPA current regarding any changes in insurance or contact information. I attest that the above information is true to the best of my knowledge.

Responsible party signature: ***Date:***

North Hills Psychological Associates, Inc. (NHPA)

CONTRACT AND CONSENT FOR EVALUATION AND TREATMENT

Client's Name _____

I understand that by signing this Agreement I am entering into a contract for NHPA to provide professional services under the following terms and acknowledgements:

1. I will provide the clinical information requested by NHPA to facilitate appropriate treatment.
2. I will work with NHPA to determine a mutually agreeable Treatment Plan and discuss any concerns or questions I have regarding these professional or administrative services.
3. I understand that no promises have been made to me as to the results of treatment provided by NHPA.
4. I will respect my commitment to follow up appointments and keep the appointments that I have scheduled. If I am unable to keep an appointment, I will give at least 24 hours notice. If I do not give this notice, I will be responsible for fees of $50 for No Show and $25 for Cancellation without 24 hours notice.
5. I understand that copays are due at the time of service. I will be responsible for payment of a $10 fee if I do not pay my copay at the time of service.
6. I understand that I may stop my treatment with my clinician at any time. I agree to give my therapist notice of this decision. I will still be responsible for paying for the services I have already received.
7. I will keep NHPA informed of current information about my address, phone numbers and insurance coverage.
8. I authorize direct payment to NHPA of any insurance benefits otherwise payable to me for provided services. I also authorize my insurance company to furnish NHPA information pertaining to my insurance benefits and the status of claims submitted by NHPA for services rendered.
9. I acknowledge that while insurance may cover part of all the fees charged by NHPA, I am ultimately responsible for the cost of the services provided. I understand that benefits quoted are not guaranteed.
10. I will fulfill my responsibilities in keeping any behavioral managed care personnel informed of requested services and comply with their authorization procedures.
11. I consent to the release to my health plan or insurance company, the medical information necessary for NHPA to secure payment for services rendered.
12. I understand that the fees for office services do not include the cost of telephone calls to provide other professional services and I agree to be responsible for the cost of these services at the rate of $2.38 per minute if more than five minutes.
13. I understand that some behavioral managed care companies want to review complete records of some patients. You may release my records without obtaining an additional release.
14. I authorize NHPA to complain to the Insurance Commissioner for any reason on my behalf.
15. My primary Care Physician, Doctor _____ Address _____ _____ Phone # _____ is responsible for my medical care (or the medical care of my child). You may inform this doctor of the diagnosis and treatments provided by NHPA. I authorize NHPA:

☐ To exchange any applicable information with my Primary Care Physician and their office
☐ Not to release information to my Primary Care Physician

16. NHPA may leave messages regarding appointments on my home answering machine and/or voicemail.
17. I have received the Notice of Privacy Practice and the NHPA Service Brochure.
18. I understand that if my account becomes delinquent, a rebilling fee of $3.00 per month will be assessed and my account could be sent to collections.
19. I understand that NHPA does not do evaluations or recommendations for the legal system. (Also, if this contract is for my child, I am aware that requesting the release of treatment plans, notes or reports for forensic purposes, or subpoenaing testimony about any of the content of my child's treatment interferes with the therapy relationship and greatly jeopardizes his/her health and wellbeing.) Therefore, I knowingly and freely waive my right to request the release of information (other than dates of sessions, length of sessions, attendance at sessions, and fee information) to my attorney or the Court. I understand that release of clinically-significant information to the Court shall be by Court Order, signed by a duly appointed Judge, only. I further understand, that if I violate this agreement and attempt to involve the therapist in a court/custody dispute, I will be billed for the therapist's time for these legal issues, at a rate of $4.76 per minute, including, but not limited to, responding to attorneys, phone calls, writing reports, supervision, preparing for court appearances, travel to and from court, etc. I understand that payment for these charges is the responsibility of the client or parent/guardian requesting them, regardless of any custody order.

Signed _____ Date _____

Client or person authorized to sign for client

ADULT CHECKLIST OF CONCERNS

Name: _____ Date: _____

Please mark all the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Gender, sexual orientation
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits

OVER

❑ Loneliness
❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Memory problems
❑ Menstrual problems, PMS, menopause
❑ Mood swings
❑ Motivation, laziness
❑ Nervousness, tension
❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection
❑ Panic or anxiety attacks
❑ Parenting, child management, single parenthood
❑ Perfectionism
❑ Pessimism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems (with friends, with relatives, or at work)
❑ School problems (see also "Career concerns . . . ")
❑ Self-centeredness
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Social Media Concerns
❑ Spiritual, religious, moral, ethical issues
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suspiciousness
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance
❑ Thought disorganization and confusion
❑ Threats, violence
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

❑ _____

❑ _____

Please look back over the concerns you have checked off and choose the one that you most want help with.

It is: _____

North Hills Psychological Associates, Inc.
www.nhpa.com
724-759-7500

10475 Perry Highway
Town Centre, Suite 110
Wexford, PA 15090

200 Cedar Ridge Drive
Cedar Ridge Business Park, Ste 204
Pittsburgh, PA 15205

6315 Forbes Avenue
Maxon Towers, Suite L121
Pittsburgh, PA 15217

INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the therapist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your therapist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Provider's Name / Signature: _____

Client Name: _____

Signature of Client/Client's Legal Representative: _____

Date: _____

NORTH HILLS PSYCHOLOGICAL ASSOCIATES, INC.

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us at 724-759-7500. This authorization will remain in effect for one (1) year from the date of signature.

Credit Card Information
Card Type: ☐MasterCard ☐VISA ☐Discover ☐AMEX ☐Other (i.e. HSA) _____
Client Name: _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____

I,_____, authorize North Hills Psychological Associates, Inc. (NHPA) to charge my credit card for balances on my account.

- I understand that my information will be saved securely on file for future transactions on my account.
- Balances on account can include insurance co-payments (copays, deductibles, co-insurance), cancellations without 24hrs notice fee(s), no show for appointment fee(s), retainers, and report writing.
- I agree not to dispute charges ("charge back") for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session.
- I further authorize NHPA to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

_____ _____

Client/Legal Guardian Signature Date