THE ALPHA CENTER
NOURISHING THE MIND, BODY & SPIRIT

NEW CLIENT REGISTRATION

If at any time questions or concerns regarding your therapy sessions arise, please let us know. Welcome. We want to make your appointments as pleasant and comfortable as possible.

Date:_____
Client Name:_____
Date of Birth:_____ Age:_____ Sex:___
Address:_____
City/State/Zip:_____
Phone: _____
Email: _____

Referred by: _____
Preferred Name:_____
Marital Status:_____
Spouse's Name:_____ Age:_____
Spouse's Phone:_____
Religious Preference:_____

Employer Information *(if applicable)*
Employer Name:_____
Phone Number:_____
Client's Occupation:_____

Person To Contact In Case of Emergency:
Name:_____
Relationship:_____
Phone:_____

General Physician:_____
Specialist:_____
Psychiatrist:_____
Other Professional:_____

Medications You Are Currently Taking:
_____
_____
_____

Names of Children/Age/DOB

_____	Age:_____	DOB:_____
_____	Age:_____	DOB:_____
_____	Age:_____	DOB:_____
_____	Age:_____	DOB:_____
_____	Age:_____	DOB:_____

Signature:_____ Date:_____

855 Central Dr Suite 31B · Odessa, Texas · 79761 · (432) 614-5720 · Fax (877) 729-4033

PERSONAL HISTORY INFORMATION

Please note: All information will be kept strictly confidential.

Briefly describe the problem(s) that brought you into this office:_____

What have you done to try to resolve this problem?_____

Are you currently receiving treatment or counseling? □ Yes □ No If so, when?_____

And whom did you see?_____

Describe your current physical health:_____

Describe your current mental state:_____

Have you been under medical care (physical or psychological) during the past year? □ Yes □ No

If yes, please describe:_____

Serious or Prolonged Illnesses:_____

Have you ever suffered a head or back injury? □ Yes □ No If yes, when?_____

Please describe:_____

Have you ever had or do you think (or fear) you have a drug or alcohol abuse problem? □ Yes □ No

If so, please describe:_____

Were either of your parents an alcoholic or drug addict? □ Yes □ No If so, please describe:_____

Any other family members or people with whom you are close to have a drug or alcohol problem?

□ Yes □ No If so, please describe:_____

Who currently lives in the home with you?_____

Please list other information that we might find useful:_____

Signature:_____ Date:_____

Please fill out all forms completely

PAYMENT AND INSURANCE INFORMATION

Please fill out all relevant information. Assignment cannot be accepted without your signature.

Method of Payment: ☐ Check/Cash ☐ Credit Card ☐ Insurance ☐ Other

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If you wish us to file on your insurance, please fill out all information completely.

Insurance provided by: ☐ Your Job ☐ Spouse's Job ☐ Other

Please provide your insurance card(s) if available.

1. Primary Coverage:_____
   Policy Holder Name:_____ Employee ID#:_____
   Social Security #:_____ Group #:_____
   Date of Birth:_____ Precertification Phone #:_____

2. Secondary Coverage:_____
   Policy Holder Name:_____ Employee ID#:_____
   Social Security #:_____ Group #:_____
   Date of Birth:_____ Precertification Phone #:_____

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY

In order for my insurance company to pay for my services, the counseling center will have to contact them for authorization. I understand this cannot be done without my written permission. I also understand this is a signed release for the express purpose of insurance payment and will be used for no other purpose.

Signature of Client:_____ Date:_____

AUTHORIZATION OF ASSIGNMENT OF BENEFITS AND PAYMENT OF SERVICES

I understand that my insurance policy is an agreement between the insurance carrier and myself and as such I have a personal responsibility to deal directly with my insurance company if difficulties arise. I, also, understand that this office will prepare necessary reports and forms to assist me in collecting payment from my insurance company and that any amount paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued payments in order to credit my account.

However, I understand that this agreement does not insure payment, nor does it relieve me of the obligation of payment of the services I have received and that all services rendered to me WILL BE charged directly to me. Therefore, I am personally responsible for full or partial payment.

Signature of Client:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act. Of 1996 ("HIPPA"). Under HIPPA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgement that this notice was received.

Therefore, I, *[please print name]*_____acknowledge that the counseling center has provided a written copy of its Notice of Privacy Practices for Protected Health Information for my review, on behalf of either myself or a client *[please specify]*_____ for whom I am acting as personal representative.

I further acknowledge that I have been provided with a copy of the counseling center's Notice of Privacy Practices for my records if I have made such a request.

_____ _____

Signature of Client or Personal Representative Date

_____

Relationship to Client

_____ _____

Signature of Witness Date