REALIGN HEALTH AND WELLNESS CENTER

CLIENT REGISTRATION SHEET

Patient Name: _____ **Home Phone: (_____)** _____
(Last) (First) (M.I.)

Address: _____ **Work Phone: (_____)**_____
(Street or P.O. Box) (Apt or Rt. #) (If minor, list parent's #)

_____ **Cell Phone: (_____)** _____
(City) (State) (ZIP)

Sex: ____M _____F **DOB:** _____/_____/_____ **SS#:**_____/_____/_____ **Referred by:** _____

Employer: _____ **Address:** _____
(if patient is minor, list parent's)

Spouse's Name: _____ **Employer:** _____ **Phone: (_____)**_____

School Name: (If Student) _____ **Grade Level:** _____

Who is responsible for payment of services (if different from above)?

Name: _____ **Relation to Client:** _____
(Last) (First) (M.I.)

Address: _____
(Street or P.O. Box) (Apt or Rt. #) (City) (State) (ZIP)

Contact Phone: (_____)_____ **DOB:** _____/_____/_____ **SS#:** _____/_____/_____

Primary Insurance: _____ **Phone: (_____)**_____

Insurance Company's Address: _____

Insured's Name: _____ **DOB:** _____/_____/_____ **Sex:** _____M _____F

Insured's ID #: _____ **Group #:** _____

Relation to Client: _____ **Employer Plan:** _____Yes _____No

Employer: _____

NOTIFY IN EMERGENCY: _____ Home Phone: _____

Relation to Client: _____ Work Phone: _____

- **I authorize the release of Private Healthcare Information required, in the course of my services with the therapist, to process third-party claims for benefits.**
- **I authorize claim's benefits for above client to be paid directly to the therapist.**
- **I authorize Realign Health & Wellness Center to contact the client through the listed above phone number and mailing address.**

_____ _____
Signature of Client or Responsible Party Date

REALIGN HEALTH AND WELLNESS CENTER

DATE: _____

Clinical Information

CLIENT NAME _____ **SSN** _____-_____-_____

This information is for your clinician to be aware of your presenting problems and any physical health conditions you may be experiencing at this time.

1. What brings you in to seek care at this time: _____
2. How is this problem effecting your work life: _____
3. Have you received previous help for this problem; When? _____
4. Would you like your faith or spiritual preferences to be considered in treatment? _____ No _____ Yes
5. Do you have a primary care physician? _____No _____Yes

   The physician's name: _____ Phone: _____

5. Are you under the care of medical specialists?_____No _____Yes

Specialist	Reason For Visit With Specialist

6. How would you rate your overall health at the present time: (Check one)

_____ Excellent _____ Good _____ Fair _____ Poor

7. About how many times have you visited any physician in the past 12 months?_____ (total number of visits)
8. How many physician diagnosed medical conditions do you have? _____(total)

9. List all the prescribed and non-prescribed medications that you take on a daily basis:

_____

_____

_____

10. Average number of hours of sleep per night: _____ hours
11. How many alcoholic drinks (including beer) do you have: _____ Daily _____Weekly
12. How often do you exercise on a regular basis? _____ times _____ (frequency) Please describe activity:

_____

13. Describe what you eat and how much you eat during the week:

_____

14. Describe what you eat and how much you eat during a weekend:

_____

15. What do you do for fun?

_____

REALIGN HEALTH AND WELLNESS CENTER

Stress Symptom and Health Care Checklists

DATE: _____

CLIENT NAME _____ **SSN** _____-_____-_____

Our reactions to stress can be quite different. The degree to which we are affected also varies. To determine whether you are being bothered by stress related problems, rate yourself on each of the following symptoms which have occurred during the past month. Circle the most appropriate answer.

In the last month I have experienced:

		never	some	often	always
1.	Tension headache	1	2	3	4
2.	Overeating	1	2	3	4
3.	Lower Back Pain	1	2	3	4
4.	Feelings of Nervousness	1	2	3	4
5.	High Blood Pressure	1	2	3	4
6.	Alcohol Consumption	1	2	3	4
7.	Stomach Indigestion	1	2	3	4
8.	Worrisome Thoughts	1	2	3	4
9.	Dermatitis (rashes)	1	2	3	4
10.	Migraine Headaches	1	2	3	4
11.	Early morning awakening	1	2	3	4
12.	Diarrhea	1	2	3	4
13.	Asthma Attacks	1	2	3	4
14.	Suicidal thoughts	1	2	3	4
15.	Common flu or cold	1	2	3	4
16.	Prescription drug use	1	2	3	4
17.	Cold hands or feet	1	2	3	4
18.	Sexual problems	1	2	3	4
19.	Inability to concentrate	1	2	3	4
20.	Difficulty making decisions	1	2	3	4
21.	Feelings of depression	1	2	3	4

In the last month I have experienced:

		never	some	often	always
22.	Difficulty falling or staying asleep	1	2	3	4
23.	Fatigue	1	2	3	4
24.	Constipation	1	2	3	4
25.	Nightmares	1	2	3	4
26.	Hives	1	2	3	4
27.	Minor infections	1	2	3	4
28.	Hyperventilation	1	2	3	4
29.	Menstrual distress	1	2	3	4
30.	Nausea or vomiting	1	2	3	4
31.	Irritable with others	1	2	3	4
32.	Loss of appetite	1	2	3	4
33.	Aching neck or shoulder muscles	1	2	3	4
34.	Colitis attacks	1	2	3	4
35.	Arthritis	1	2	3	4
36.	Minor accidents	1	2	3	4
37.	Peptic ulcer	1	2	3	4
38.	Heart palpitations	1	2	3	4
39.	Angry feelings	1	2	3	4
40.	Difficulty talking with others	1	2	3	4
41.	Feelings of low self worth	1	2	3	4
42.	Allergy problems	1	2	3	4

SCORE: _____

40 55	55 75	75 95	95 115	115 130+
LOW	**AVERAGE**	**ABOVE AVG**	**HIGH**	**EXTREME LEVEL**

REALIGN HEALTH AND WELLNESS CENTER
INFORMED CONSENT

Health Insurance Portability & Accountability Act

MENTAL HEALTH ASSESSMENT AND TREATMENT

All new patients will receive a mental health assessment to determine the best course of treatment for their presenting problem. The assessment includes a diagnostic interview to be completed by the therapist, and may include questionnaires or particular assessment instruments to be completed by the client. As part of the diagnostic assessment, you may be asked to complete specific assessment or testing instruments, the cost of these instruments, interpretation and report (if necessary) will not be billed to your insurance carrier. The patient or patient's authorized representative is solely responsible for those fees. Since all assessment and testing devices are proprietary instruments, the instruments and data are restricted from non-professionally trained individuals including patient and patient's parents and/or legal guardians. The diagnosis from these assessments will become part of the medical record and the insurance record. If you choose to use your insurance benefit and wish to file for third party reimbursement, please refer to the Client Information Sheet and the Provider Notice of Information Practices for the limits of confidentiality. The principal diagnosis and treatment plan for your presenting problem may, or may not, be a covered benefit in your benefit plan. If your plan will not cover the services that you wish, or if you elect not to use your insurance benefit to ensure total confidentiality, the therapist will discuss contracting for services on a private pay basis.

EMERGENCY PROCEDURES

If you have a life - threatening emergency, call 911 and/or seek assistance at the closest emergency medical facility.

PAYMENT POLICIES

1. Payment in full is expected at the time services are provided unless alternative arrangements are agreed to in advance, in writing. If you are a member of an EAP, HMO, PPO, or other managed care organization, you may be responsible for obtaining an authorization number prior to receiving services. If proper initial authorization is not obtained, you will be responsible for the full cost of the services rendered. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions regarding the validity of this balance, it is your responsibility to contact our office within 30 days after receipt of the initial statement. **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be referred to a collection agency and/or attorney for further collection activity. You will be responsible for paying all collection costs including attorney fees. You are responsible for informing the therapist of any other health insurance you may possess in addition to your primary insurance carrier. Failure to do so may result in you being liable for payment of services rendered if your insurance company fails to pay due to inadequate coordination of benefits. In addition, the therapist has a legal and contractual obligation to collect your co-payment at the time professional services are rendered.

2. If you wish to revoke authorization for the therapist to release your private healthcare information to your insurance carrier, you must do so in writing.

3. The therapist will charge a fee for missed appointments and for those appointments canceled with less than 48 business hours of notice. If a client wishes to cancel an appointment, the client must contact the office during the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday to avoid being charged for a missed appointment. **The fee for a missed appointment is $75.00 for individual, marital or family sessions.** For missed or late cancelled group sessions, the regular group fee will apply. This fee is due immediately upon notification to the client and must be paid prior to the next appointment. Note that fees charged for missed and late cancelled appointments are not reimbursable by insurance companies. Thus, clients will be personally responsible for payment of such fees.

4. Telephonic therapy or all non-emergency (non-life threatening) telephone calls will be billed to the client at a rate of $75.00 per fifteen minute time interval or $300.00 per hour. Each fifteen minute interval begins at the first minute of the call or at the first minute following the last interval.

5. Court Appearances, medical testimony, legal conferences and / or preparation for court as well as transportation to and from are charged at the rate of $350.00 per hour with a minimum of four hours or $1,400.00. The minimum fee of $1,400.00 and notice of court date must be provided at least seven days in advance of the actual court date. Any additional hours will be charged at $350.00 per hour. If during the first visit it is determined that a court appearance or medical testimony will be necessary, the minimum fee of $1,400.00 must be paid in advance and the funds will be held in trust until said court appearance occurs or the case is settled.

6. Copies of patient records require a written authorization from the patient before they will be provided. There is a $75.00 charge for records with a $1.00 charge per page for each additional page over 50. Administrative services (i.e. Letters, FMLA Forms, Disability Forms, Diagnostic Evaluations, etc.) will be billed at a rate of $225.00 per hour with a minimum of 30 minutes or $112.50. Documents and services required to be completed within 48 business hours will incur a $75.00 expedited service charge. Returned checks will incur a $35.00 charge.

7. My signature on this page means that I have read and understand the information presented above, and that I have the legal right to make such agreements. I am agreeing to the mental health assessment and all mental health treatment reviewed and discussed with me by my clinician. I also state that I have read and understand the Client Information Form and Informed Consent document.

Signature of Client or Parent/Legal Guardian	**Signature of Client or Parent/Legal Guardian**
Client's Name (Printed)	**Witness to Consent**
SSN	Date

Copy to be maintained in patient chart and copy given to patient

Reised 1/1/2015

REALIGN HEALTH AND WELLNESS CENTER

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

CONSENT FOR USE AND DISCLOSURE for TREATMENT, PAYMENT & HEALTHCARE OPERATION

Patient name: _____ **Social Security:** _____

Section A: Consent for Treatment, Payment and Health Care Operations

I hereby consent for the use or disclosure of my individually identifiable health information to carry out treatment, payment or health care operations. This includes assignment of benefits.

This consent is authorized for (circle one):

Dr. Demond Spraberry, CPT, FNS, CFMP or Dr. Shae Spraberry, LPC.

I understand that I have the right to review this office's Notice of Information Practices as displayed in the waiting room.

I have received a copy, and read the Notice of Information Practices posted in this office and understand its meaning as evidenced by my signature.

_____ _____

Signature of patient or patient's legal representative **Date**

_____ _____

Printed name of patient's legal representative **Relationship to patient**

Section B: Right to Revoke Consent or to Restrict Protected Health Information Disclosure

I understand that I have the right to request that this provider restrict how protected health information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that the provider is not required to request restrictions.

I have the right to revoke the consent in writing except to the extent that the provider has taken action prior to the revocation. I understand that this authorization is voluntary.

List Requested Restrictions Approved/Denied by Provider (circle one/initial)

_____ Approved Denied _____

Specific description of information (including date(s): _____

_____

_____ _____

Signature of patient or patient's legal representative Date

_____ _____

Printed name of patient's legal representative Relationship to patient

I want to revoke my authorization for treatment, payment, and health care operations beginning on _____, 20____.

_____ _____

Signature of patient or patient's legal representative Date

§164.506
§164.532

Dr. Demond Spraberry, CPT, FNS, CFMP _____

Dr. Shae Spraberry, LPC _____
(Please check your provider)

INFORMED CONSENT
Health Insurance Portability & Accountability Act

AUTHORIZED CONSENT FOR DIAGNOSTIC TESTING

I _____ understand, per the terms of the Informed Consent, that the cost of testing is the sole responsibility of the patient or the patient's authorized representative. The instruments, interpretation, and report (if necessary) will not be billed to my insurance carrier. Testing is self-pay only service of Realign Health and Wellness Center.

My clinician has explained the benefits and risks of these diagnostic tests. I am fully aware of these risks and have been given the opportunity to ask questions pertaining to testing. My questions have been answered by my clinician regarding the benefits and concerns. I am satisfied with the explanation and want to continue with the testing.

I understand the cost for the testing and agree to the fees outlined by my therapist.

I understand that it is my responsibility to make payments on these fees at each session, and that my balance will be paid in full at the completion of testing.

I understand a written report will not be issued unless an entire assessment battery is performed. If a written report is requested, I will be billed at the administrative services rate disclosed in the Informed Consent.

Signature of Client or Parent/Legal Guardian	**Signature of Client or Parent/Legal Guardian**
Client's Name (Printed)	**Witness to Consent**
SSN	**Date**

Copy to be maintained in patient chart

REALIGN HEALTH AND WELLNESS CENTER

3295 S. Cooper St Suite Arlington, Tx 76015

PH:**817 953 6316** FAX: **817 953 6347**

GOALS OF THERAPY

The goals of therapy are to provide information, emotional support, and skills to improve personal effectiveness, preserve personal safety, and to develop problem solving strategies to deal with current problems. Psychotherapy has both benefits and risks. Psychotherapy has been shown to produce significant improvements in emotional well being, family and personal relationships, and work and school performance. Risks include experiencing uncomfortable levels of feelings like frustration, sadness, guilt and loneliness. Although therapy can be a powerful life changing process, there are no guarantees about what will happen. Therapy has a natural process to it, which includes a beginning (getting acquainted, identifying problems, setting goals), a middle (treatment activities – exploring approaches, developing solutions), and an ending (evaluation of goal attainment, after care goals, closure activities). I hope that you will see your therapy through all of these phases.

The first therapy session is called a Diagnostic Intake. This session, and sometimes part of the second session, focuses on identifying your problems, needs, issues, goals and planning treatment interventions. These interventions could include individual, family, couples or group sessions. Not all diagnoses and treatment modalities are included as covered benefits in all health plans. I will work with you to ensure that, if you choose to use your insurance benefits, you may do so in the most effective manner. If you are unable to use your benefit, or if you choose not to in order to preserve full confidentiality, I will assist you in making payment arrangements based on a private pay basis.

ETHICAL CONSIDERATIONS

Your welfare is my primary concern. I am bound by and follow the American Association for Marriage and Family Therapy Code of Ethics. As a Licensed Marriage and Family Therapist I am required to follow the mental health laws in the State of Texas, in order to ensure your welfare and the highest quality of behavioral health care.

LENGTH OF THERAPY

Therapy is designed to accomplish goals that you and I develop. The time it takes to reach your goals varies with your individual needs and circumstances. The method, duration and frequency of your sessions will be determined during treatment. However, your insurance carrier may choose to only authorize payments for service they deem to be medically necessary. – Typically, in the early phases of treatment, individual, couple and family sessions are conducted once a week or every two weeks. As therapy progresses, the sessions are held less frequently. Therapy sessions vary in length. Individual, couple, and family sessions can range from 20 to 45 minutes.

CLIENT SATISFACTION

Office Practices and Billing Concerns: It is important that we resolve any concerns about office practices or billing matters. If you have concerns about these issues, please feel free to discuss this during your session.

Therapy Satisfaction: It is important you feel that your therapy is beneficial to you. You always have the choice to discontinue therapy or be referred to another therapist. If this is your choice, I will be available to help you through this transition.

Grievances: I encourage you to discuss any problems you have with me directly. I am willing to work with you to resolve identified problems in order for you to accomplish your therapeutic goals

EMERGENCY PROCEDURES

During regular office hours, Monday – Friday 8:00 a.m. – 5:00 p.m. you may contact my office. However, if you have a life threatening emergency, call 911 and/or seek assistance at the closest emergency medical facility. For non-emergency (non-life threatening) telephone calls will be billed to the client at a rate of $75.00 per fifteen minute time interval or $300.00 per hour. Each fifteen minute interval begins at the first minute of the call or at the first minute following the last interval.

DIAGNOSTIC, EDUCATIONAL, AND CAREER ASSESSMENTS

During treatment, we may decide that you need a diagnostic evaluation or other assessments to help determine various aspects of your presenting problems, treatment needs or after care. I will discuss the purpose of the evaluations and/or assessments, the general procedures and the estimated cost. In most circumstances testing is not a covered benefit of your health plan. I will discuss the assessment cost with you in order for you to make an informed decision about this course of action.

CONFIDENTIALITY

Information about you and your treatment is considered private and confidential. No personal information about you or your treatment will be released to others except as allowed by legislation. Note that there are circumstances that may compel me to reveal information. The major, relevant limitations to confidentiality are noted below:

- As directed in writing by you, your legal guardian, or legal guardian of a minor client.
- In an emergency, if it is determined that there is a probability of imminent physical injury by the client to the client or others, or there is a probability of imminent mental or emotional injury to the client. In those cases, law enforcement personnel and/or family members may be contacted.
- As necessary to obtain payment for services. This may include giving information to insurance companies for payment of services, to whomever you identified as the financial responsible party for the cost of services, or to a collection agency.
- As directed by a court order subpoena
- As required by State and Federal law to protect children or the elderly. For example, the law requires that if a reasonable cause exists to believe that child or elder abuse is occurring to a client or non-client, then that situation must be reported to Child or Adult Protective Services.
- To inform the party that referred you and only so far as to provide basic information (e.g., that you did indeed arrange for services, the name of your therapist).
- And other circumstances as authorized by law.

FEES FOR SERVICES

Treatment: Payment in full is expected at time services are provided unless other arrangements have been made in advance, in writing, or the patient is a member of an EAP, HMO, PPO or other managed care organization.

Diagnostic Testing: As part of the diagnostic assessment, you may be asked to complete specific assessment or testing instruments, the cost of these instruments, interpretation and report (if necessary) will not be billed to your insurance carrier. The patient or patient's authorized representative is solely responsible for those fees.

Late Cancellations and No Shows: Patients are expected to contact the office 48 hours prior to their scheduled appointment if they need to cancel or reschedule. There is a $75.00 fee for all missed appointments with less than 48 hours (standard business hours) notice. Payment must be made before future appointments are made.

Court Appearances: In the event that I am requested by the client, the client's parent/legal guardian, or I am subpoenaed or court ordered to appear in court by a source other than the client/parent/legal guardian, the client and/or the client's parent or legal guardian is expected to pay for the time spent in preparing for the court appearance as well as the time spent for transportation to/from court and appearing in court at the rate of $350.00/hour. The minimum charge is for four hours or $1,400.00 to be paid no later than 2 weeks prior to the scheduled court date. This fee is not reimburseable by a Third Party Payer and is therefore the full responsibility of the client and/or the client's parent or legal guardian. Payment is due prior to the rendering of these services via cash, Discover, Visa, MasterCard, money order, or a cashier's check.

Administrative Services: Copies of patient records require a written authorization from the patient. There is a $75.00 charge for records with a $1.00 charge per page for each additional page over 50. Copy of client records will be sent free of charge to other health care providers in order to coordinate care. Administrative services (i.e. Letters, FMLA Forms, Disability Forms, Diagnostic Evaluations, etc.) will be billed at a rate of $225.00 per hour. There is a $35.00 charge for returned checks.

Collection of Outstanding Debt: Patients are expected to be up to date on their account. Our office sends notice of outstanding debt for up to 120 days and then the account is sent to a collections agency. Once the debt has been sent to collections the matter is between the collection agency and the patient.