RITA L. DAVIS, LCSW

New Patient Registration

Name of Patient: _____Marital status_____

Name and relationship to Patient if not completed by patient _____

Patient's home address: _____

City _____ State _____ Zip _____

Phone: **landline**: _____ ***Cell:** _____Work:_____

*Rita Davis will send a reminder text for your appt. to your cell

Date of Birth: _____

Patient's Social Security**#** _____

Patient's employer or School_____

Spouse :_____**Spouse phone** _____

In Case of Emergency call_____ Phone_____

Referral Information: How did you hear about us? _____

If specifically referred, by whom?_____Phone_____

Are you currently seeing another therapist? _____If so, name_____

Address_____Phone_____

INSURANCE INFORMATION FOR BILLING:

Insurance #1_____Policy#_____

Group# _____Name of Insured _____

Insured DOB: _____Relationship to Patient:_____

Insured Employer_____

Insurance #2 _____Policy#_____

PLEASE LIST ANY OTHER INSURANCE SO THAT WE MAY BILL APPROPRIATELY:

_____

Address of Insured if different than above: _____

RESPONSIBLE PARTY INFORMATION: RESPONSIBLE PARTY MUST BE PRESENT AND SIGN ALL FORMS. Please ask for assistance if this is not possible.

Name: _____Relationship to patient: _____

Date of Birth_____Social Security#_____

Address_____City_____

State_____Zip_____ Phone_____

CONFIDENTIALITY CONTRACT

The law protects the privacy of all communications between us. I will only release information about your treatment to others when you request it by signing a written release form. However, there are some exceptions. Your signature on this agreement indicates your consent to the following exceptions to confidentiality.

-Child Abuse: In certain circumstances, I am required to report child abuse in a variety of forms, including neglect, to either a local law enforcement agency, or the office of the Department of Health and Human Services (Dept. of Social Services) in the county where the child resides.

-Adult/Elder Domestic Abuse: If I have reasonable cause to believe that an incapacitated adult is being abused, neglected or exploited, I must immediately report that information to the Department of Health and Human Services/Social Services. In cases where an adult dies as a result of patient's actions of physical abuse or assault, I must immediately report that information to local authorities.

-Threat to injure oneself or someone else: When a threat to injure or kill oneself is communicated to the therapist, or when a serious threat or harm to someone else is communicated to the therapist, I will contact the appropriate help to make sure the person is safe.

-Medical Release: I will only release confidential information about you to anyone if you have signed a Release of Information either by Rita Davis or another person/company.

-Under 18: Patients under 18 do not have full confidentiality from parents.

-Other Limits: All records, as well as notes on sessions and phone calls could be subject to court subpoena under extreme circumstances.

I have read and understood the information in the agreement and raised any questions I have about it with the therapist. I give my consent to the terms of this document and agree to enter into the therapeutic relationship.

Client Signature _____Date_____

MISSED/CANCELLED APPOINTMENT POLICY FOR
RITA DAVIS, LCSW

Your appointment commits Rita Davis' time to you . When inadequate notice is given to cancel your appointment, Rita Davis is unable to offer this time to another patient. Please provide at least 24 hours advance notice if you are unable to keep a scheduled appointment. A fee of $75.00 will be charged to your account if you do not cancel within 24 hours. You will not be able to schedule another appointment until the late fee is paid in full.

Client_____Date_____