REGISTRATION

NAME ____

Address______________________________ City_______________ State___ Zip ________

Date of Birth _____________ Sex M / F SSN#_______________________

Marital status: Single Married Divorced Separated Widowed

Home phone#____________________ Cell # ____________________

Email ___________________

Emergency Contact:

Name: ________________________________ Phone# _______________________

Relationship to patient: ____

Primary Care Physician __________________________ Office Number __________________

Employer____

Address__________________________ City__________________ State___ zip _______

Work phone______________

Name of person insured__________________

Relationship to insured (self, spouse, child, other)

Policy Holders birth date _____________ Social Security Number __________________

Spouses Information

Name __________________________ Date of birth _____________ SSN#__________________

Address (if different from above)

____

Insurance Information

Primary Insurance Company____

Name of person insured______________________ ID # ____________ Group #____________

Relationship to insured (self, spouse, child, other)

Policy Holders birth date ___________ Social Security Number _________________

Secondary Insurance Company ____

Name of person insured ______________________ID # ____________ Group # ____________

Relationship to insured (self, spouse, child, other)

Policy Holders birth date ___________ Social Security Number_________________

I hereby assign my insurance benefits to be paid to NorthWest Counseling & Associates. I understand that I am financially responsible for this bill regardless of insurance coverage. I also authorize release of any information required in the processing of my insurance claims. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree in the event of non payment, to assume the costs on interest collection and legal action (if required).

____

Patient Signature Date

____

Guarantor's Signature (if pt is a minor) Date

Revised 11/13

HEALTH HISTORY

PATIENT INFORMATION

NAME____ DATE OF BIRTH ____________________

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

Medications	Dose	Times daily	Medications	Dose	Times Daily

WHAT OVER THE COUNTER MEDICATIONS, HERBAL AND SUPPLEMENTS ARE YOU TAKING?

Medication	Dose	Times daily	Medication	Dose	Times Daily

ALLERGIES (MEDICATIONS, FOOD, ETC)

MEDICATION	FOOD / SUBSTANCE	REACTION / SYMPTOMS

HEALTH HISTORY

CHECK THE BOX IF YOU HAVE A **FAMILY HISTORY** OF THE FOLLOWING:

	HYPERTENSION		KIDNEY DISEASE
	HIGH CHOLESTEROL		RESPIRATORY DISEASE
	CANCER		THYROID DISORDERS
	DIABETES		STROKE

CHECK THE BOX IF YOU HAVE **A PERSONAL HISTORY** OF ANY OF THE FOLLOWING:

	HYPERTENSION		KIDNEY DISEASE
	HIGH CHOLESTEROL		RESPIRATORY DISEASE
	CANCER		THYROID DISORDERS
	DIABETES		STROKE
	LIVER DISEASE		GASTRIC DISORDERS
	MAJOR HOSPITALIZATIONS		

CHECK THE BOX IF YOU HAVE A **PSYCHIATRIC FAMILY HISTORY** OF THE FOLLOWING:

	DEPRESSION		ANXIETY
	ADHD		SUICIDE ATTEMPTS
	SCHIZOPHRENIA		OTHER:
	BIPOLAR DISORDER		
	SUBSTANCE ABUSE/ ALCOHOL ABUSE		
	MAJOR HOSPITALIZATIONS		

CHECK BOX IF YOU HAVE A **PERSONAL PSYCHIATRIC HISTORY** OF THE FOLLOWING:

	DEPRESSION		ANXIETY
	ADHD		SUICIDE ATTEMPTS
	SCHIZOPHRENIA		SUBSTANCE ABUSE/ ALCOHOL ABUSE
	BIPOLAR DISORDER		
	MAJOR HOSPITALIZATIONS: LIST		

HEALTH HISTORY

CURRENT PSYCHIATRIC SYMPTOMS: CHECK THE CORRESPONDING BOX

	ANXIOUS		AUDITORY HALLUCINATIONS		GUILT
	HOPELESS		VISUAL HALLUCINATIONS		GRIEF
	PARANOIA		OLFACTORY HALLUCINATIONS		PANIC ATTACKS
	CONCENTRATION PROBLEMS		TACTILE (TOUCH) HALLUCINATIONS		MANIA
	DEPRESSED MOOD		GUSTATORY (TASTE) HALLUCINATIONS		BEHAVIORAL PROBLEMS
	DECREASED ENERGY		DELUSIONS (BIZARRE THOUGHTS)		TEARFULNESS
	IMPULSIVITY		LOSING LAPSES OF TIME		WORRY
	IRRITABILITY		HYPERACTIVITY		WEIGHT GAIN
	INAPPROPRIATE ANGER		DISSOCIATION (OUT OF BODY)		WORTHLESSNESS
	SELF-INJURIOUS BEHAVIOR		INAPPROPRIATE EUPHORIA		WEIGHT LOSS
	MEMORY PROBLEMS		OBSESSION/ COMPULSIONS		TOO MUCH SLEEP
	DECREASED / NO INTEREST IN SEX		SOMATIC COMPLAINTS (EX. PAIN)		
	DECREASED SLEEP		DISTURBED SLEEP		

THOUGHTS OF WANTING TO DIE? YES NO IF YES, EXPLAIN WHY

____

____

DO YOU HAVE A SUICIDAL PLAN TO HURT YOURSELF? YES NO
IF YES, EXPLAIN HOW YOU WOULD DO THIS.

____

____

____

DO YOU HAVE A HOMICIDAL PLAN TO HURT SOMEONE ELSE? YES NO
IF YES, EXPLAIN WHO YOU WOULD HURT AND HOW.

____

____

____

INFORMED CONSENT TO TREAT

I understand my signature below includes acknowledgment that I am legally authorized in my own or my child's health care and medical decisions. I authorize treatment at this office according to the individualized treatment plan.

I have voluntarily chosen to seek services and I understand that I may terminate treatment at any time.

I understand that during the course of treatment, material may be discussed that may be upsetting to me.

I understand that records will be maintained according to state laws regarding confidentiality of such information and that my information will only be released with my written permission.

I understand that state laws require that my provider to report all cases of physical or sexual abuse or neglect of minors or the elderly and all cases in which the patient presents a danger to himself or others.

____

Patient's Signature   Date

____

Parent or legal guardian Signature   Date

Dismissal with Cause Policy

Termination of the Provider / Patient Relationship

The providers at this office can terminate your services based on any of the below.

• Non-payment for services (co-pays, no show, cancellation and all other fees)

• Excessive missed appointments (more than two) or canceled follow-up appointments

• Failure to follow agreed upon treatment plan

• Untruthful about other medical services you receive.

• Attempts to perpetrate a fraud (asking to be seen without an appointment, asking to fill out fraudulent mental health or disability paperwork)

• ACCCHS recipient, providers at this office cannot provide services to you. The care provided at our office can be found under these types of plans throughout the valley (Phoenix, Goodyear, Glendale, Peoria, and Surprise etc).

• The refusal of a patient to maintain acceptable behavior. Arguing with any of our staff is not tolerated. Unacceptable behaviors include screaming, cursing, verbal or physically threatening. If any client in our office feels threatened by your behavior you will be dismissed from our office.

• Termination may give you 30 days to find another provider or it may be immediate.

• When services have been terminated at our office, you may initially be told verbally and followed up with a letter sent or directly handed to you. A copy of that letter will be kept in your patient file.

• We will make every effort to contact your other healthcare providers, which we are aware of, that the provider(s) at this office no longer offer you services.

• Calling our office for an appointment after you have been terminated is not acceptable. You will not be able to make an appointment.

Signature ____ Date ___________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had the opportunity to review the privacy practices.

Name (print) Date

Signature

FEES

All the listed fees are our self pay rates. These fees are to be paid at the time the service is rendered.

☐ **Psychiatrist**

Initial Evaluation	$ 150
Medication Management	$ 65
Individual Therapy/ meds (20 - 30 min.)	$ 75
Suboxone- Initial visit	$ 350 (due at 1st visit) (Covers 1st & 2nd visit)
All other Suboxone visits	$ 75

☐ **Therapist**

Initial Evaluation	$ 110
Each 45-50 minute session thereafter is	$ 90

☐ Miscellaneous Fees

If you have fees in this category, these need to be paid **before** you will be able to schedule another appointment.

Copying	25₵ per page
Letter to return to work/ school - each time	$ 50
No show – 1st	$ 25
Each no show after the 1st	$ 50
Late cancellation (if you cancel less than 24 hours before appointment)	$ 25

By signing below you agree to pay the above rate in the event that your visit is not covered under your insurer. I further consent to participate in evaluation and/ or treatment. I understand that I may withdraw from treatment at any time.

Name of Patient (please print) ____

Signature ____

Guarantor's Signature (if pt is a minor) ____

Date __________________

OFFICE POLICY

- All COPAYS & CO-INSURANCES must be paid in **FULL** at scheduled appointments.

- Any patient balances must be paid in full within 60 days of occurrence, including any insurance costs, no shows and/or late cancellation fees. Any patient balances that are not paid within a 60 day period are subject for termination from Northwest Counseling & Associates, LLC.

- Controlled medications will not be filled via fax or via Dr. Nellas calling in said medications. Patients will only receive refills for controlled medications by script, written at a scheduled appointment with Dr. Nellas **ONLY**.

- If a patient has not been seen for over three months, an appointment must be made to receive any refills. **No exceptions will be made.**

- Patients are responsible for making timely appointments prior to medications running out. Patients should not expect to be able to book an appointment the same day they call in, same day appointments are **never** guaranteed.

- If you are enrolled in an Employee Assistance Program (EAP) through your employer, please make sure you have the proper authorizations **AND** paperwork prior to your initial appointment with any of the counselors.

- Dr. Nellas does not call in any prescriptions to any pharmacy. If a patient is eligible for a refill, they must call their pharmacy and ask for a refill request. Any new medication prescribed requires an appointment.

- No provider at Northwest Counseling & Associates, LLC will perform disability paperwork of any kind.

- We accept cash, credit, or debit cards. **No checks are accepted.**

- Northwest Counseling & Associates, LLC reserves the right to refuse services to anyone.

REGARDING INSURANCE BILLING:
Every attempt is made to comply with your insurance company's requirements. Since policies and benefits differ among employers and individuals participating with each insurance company, we are unable to know the specifics of your policy. Your insurance company informs **ALL** participants that is ultimately your responsibility to verify benefits and coverage information prior to having any services rendered. Northwest Counseling & Associates, LLC cannot guarantee the costs of services performed will be covered by your insurance.

Insurance companies require submission of all claims within specified time limits. If you have a change in your insurance, and fail to inform us of the change, we may not be aware until your insurance company denies a claim. Denials often arrive after the filing limits have expired, preventing us from re-filing the claim with another insurance company. **To limit the charges you may be responsible for, please ensure that we always have up-to-date information regarding your insurance coverage.**

- To avoid any confusion, patients should contact their insurance company regarding their plan/benefits (deductible, co-pays, co-insurances, etc) prior to their scheduled appointment and/or change in insurance plan. Northwest Counseling & Associates, LLC is not responsible for interpreting your insurance plan for you.

OFFICE POLICY

- Patients are expected to know the requirements of their insurance plan, and if any pre-authorizations are needed to be done so by the patient prior to their scheduled appointment. If the patient fails to have any authorizations needed prior to their scheduled appointment, the appointment must be rescheduled until the necessary authorizations are given.

By signing below, you are agreeing to the above policies of Northwest Counseling & Associates, LLC.

Patient Signature Date

Guarantor's Signature (if patient is a minor) Date