Temanos Counseling Center · Ginna Maus, LCSW
231 N. Third Ave, Ste. 201 Sandpoint ID 83864 Phone: (208) 263-8948 Fax: (208) 265-1779
Email: temanos@frontier.com Website: www.temanos.com

Adult Registration

Client Name: _____Married: Y__N__ SSN_____M__ F__DOB: ___/___/____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Referred by: _____ Age: _____

Client/Parent Email Address _____ Client's Physician: _____

Person to Contact in Emergency: _____Relationship_____Phone: _____

PRIMARY INSURANCE INFORMATION

BPA/EAP/RBH? EAP Provider_____
(Circle one)

Please complete this section regardless of coverage.

Full Name of Insured: _____ Relationship_____ DOB: ___/___/___ SSN_____

Home Address: _____ Phone: _____ Employer _____

Primary Ins. Co.: _____ ID#: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Full Name of Insured: _____ Relationship_____ DOB: ___/___/___ SSN_____

Home Address: _____ Phone: _____ Employer: _____

Secondary Ins. Co.: _____ ID#: _____ Group #: _____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions and release of information to my ins. co.
2. I authorize the release of information between my primary physician and this agency.
3. I understand that I am responsible for the full amount of my bill including deductible, co-pay and unpaid insurance costs.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.
6. There will be a **$40.00** service charge on all returned checks and for appointments that are not cancelled within 24 hours.

PRIVACY PRACTICES

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We encourage you to review our Notice of Privacy Practices carefully. It provides more details on how we may use and disclose your information. In signing this form, I grant my consent to the practitioner's use and disclosure of my protected health information for the purpose of treatment, staffing, medical supervision, payment, and health care operations. You acknowledge that you had an opportunity to review our Notice of Privacy Practices prior to signing this consent. If you feel that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing.

By signing this form you are acknowledging that you have read the Notice of Privacy Practices and that a longer version is available upon request.

Signature: _____ _____
Client Signature Date

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RELEASE OF INFORMATION

Client Name: _____ SSN: _____ DOB: _____

The purpose for which this disclosure is being made is for Mental Health Therapist/Counselor.

I give my consent for a release of Information between Temanos Counseling Center and the following:

_____ _____ _____

_____ _____ _____

Information to be released:
Medical Reports ( ) Psychiatric Evaluations ( ) Therapist Notes/Reports/Evaluations ( ) Medications ( ) Other ( ) _____

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. Information released or exchanged may include any written or oral reports. I hereby release them as well as any agents and employees thereof from all liability resulting from the disclosure and exchange of the above information and documents. This release is valid as long as the client is being seen at Temanos Counseling Center, unless terminated earlier by written notification by me.

My Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to Patients. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws .and that if you have authorized us to release information to the parties you listed above under the release of info section.

Signature: _____ _____
Client Signature Date

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I understand that as a client of Temanos Counseling Center (TCC), I am eligible to receive mental health services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several months.

I understand that a range of mental health professionals provide TCC services. All clinicians are supervised by licensed clinical and medical staff. I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medication is prescribed by your primary care physician and not TCC staff.

If I have any questions regarding this consent form or about the services offered at TCC, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by TCC. I understand that I may stop treatment at any time.

You, as the client, can at this time or any other time utilize the services of another clinician inside and/or outside of TCC. We will gladly assist with the transition to another clinician if you're dissatisfied with the services you are receiving.

Client Signature Date