SPENCER PSYCHIATRIC & COUNSELING SERVICES

REGISTRATION FORM

Today's Date

Next Appointment.

PATIENT INFORMATION

Patient Chart #: **Resp Party Name** **Birthdate:** **Sex:** **Date Registered:** **Patient SSN#:**

Patient Name:

Home Phone #: **Work Phone #:** **Alt Phone #**

Responsible Party Address | **Patient Address**

Emergency Contact Name:

Emergency Phone #;

City: **City**

Referring Dr #:

State: **State** **Zip**

#

PT OK'D Contact: Y or N

INSURANCE INFORMATION

Primary Insurance Carrier:

Policy Holder:

Policy ID#

City: **State:** **Zip Code:**

Subscriber DOB

Employer:

Secondary Insurance Carrier:

Policy Holder:

Policy ID#

City: ***State:*** ***Zip Code:***

Subscriber DOB:

Employer:

Tertiary Insurance Carrier:

Policy Holder:

Policy ID#

City: **State:** **Zip Code:**

I authorize the release of any medical or mental health information necessary to process this claim. I authorize payment of benefits to any and all providers of services rendered by Spencer Psychiatric & Counseling Services.

Patient/Guardian signature *Date*

I authorize psychiatric care at SP&C Services. I permit the doctor, his employees and all other persons caring for me to treat me in ways they judge beneficial to me. I understand that this care may include exams, tests, medical and/or psychiatric treatment. We reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.

Patient Guardian signature *Date*

Spencer Psychiatric &
Counseling Services LLC
PO Box 680
Spencer, IA 51301

Spencer Psychiatric & Counseling Services L.L.C.

Patients Rights & Responsibilities

Patient's
Name____

Spencer Psychiatric & Counseling Services L.L.C. is committed to treating patients in a manner that respects their rights. We recognize that each patient has that right to the following:

The right to receive information about your managed care organization, its services, its practitioners and providers, and the patient's rights and responsibilities.

The right to be treated with respect and recognition of their dignity and right to privacy.

The right to participate with practitioners in decision making regarding their health care.

The right to full discussion of treatment options.

The right to voice complaints or appeals about the managed care organization of the care provided.

Each patient is responsible for cooperating with those providing health care services to the patient and shall have the following responsibilities.

The responsibility to provide, to the extent possible, information that the managed care organization and its practitioners and providers need in order to care for them.

The responsibility to follow the plans and insturctions for care that they have agreed upon with their providers.

____Parent/Patient

Date________________________

I have an advanced psychiatric directive. Yes No

Acknowledgement of Receipt of Notice of Privacy Practices

Spencer Psychiatric and Counseling Services, LLC

Patient Name (print): ______________________________

Social Security Number: ______________________________

Date of Birth: ______________________________

I, the patient, acknowledge that the above-listed Spencer Psychiatric and Counseling Services, LLC has given me a copy of its Notice of Privacy Practices, which explains how my Protected Health Information will be used and disclosed in various situations.

______________________________ ______________
Signature of patient or parent or legal guardian Date

____
Printed name of patient

____
Printed name of parent or legal guardian (if applicable)

____
Relationship to patient (if applicable)

For clinician use only:

If unable to obtain acknowledgement, please document dates and circumstances of attempts below. Use the back of this sheet for additional documentation if necessary.

	Date of attempt:	Circumstances prohibiting completion of Acknowledgement:
1)	__________	______________________________
2)	__________	______________________________
3)	__________	______________________________

SPCS

SPENCER PSYCHIATRIC
& COUNSELING SERVICES

Spencer Psychiatric and Counseling Services (SPCS) Authorization for Use and Disclosure of Information for Purposes Requested by a Healthcare Office

I, ______________________, hereby authorize SPCS to: Use and /or disclose the following Protected Health Information to: ______________________

___Psychiatric Evaluation ___ Psycho/Social Evaluation ___ Substance Abuse
___Medication Notes ___ Medication List ___ HIV/AIDS
___Laboratory Results _ Treatment Plan
___Verbal and Written

___ All of Above Information

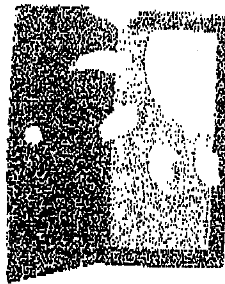
This Protected Health Information is being used or disclosed for the following purposes: Treatment, Continuity of Care, Collaboration, Referral and/or health care operations. This Authorization shall be in force and effect until **12 months** from the date signed or termination of services whichever comes first at which time this Authorization to use or disclose this Protected Health Information expires. I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to **SPCS** 2016 Hwy Blvd, PO Box 680 Spencer Iowa 51301. I understand that a revocation is not effective to the extent that **SPCS** has relied on the use or disclosure of the Protected Health Information. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. **SPCS** will not condition my treatment, on whether I provide Authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the Protected Health Information to be used or disclosed as permitted under federal or state law. **I have the right to refuse to sign this Authorization.**

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative (PRINT)

____
Description of Personal Representative's Authority



Spencer Psychiatric and Counseling Services (SPCS) Authorization/Request for Release of Information for Purposes Requested by a Healthcare Office from Another Covered Entity

I, ______________________________, hereby authorize

______________________________. To disclose the following Protected Health Information to ___SPCS___:

___ Medical History/Exam
___ Inpatient Records
___ Psychological Reports
___ Social History
___ Lab Results
___ Substance Abuse
___ Medication List
___ Progress Notes
___ HIV/AIDS
___ Psychiatric Evaluation
___ Verbal and Written
___ All of Above Information

This Protected Health Information is being used or disclosed to carry out treatment, continuity of care, collaboration, payment and/or health care operations of **SPCS.** This Authorization shall be in force and effect until **12 months** from signature date or termination of services which ever comes first at which time this authorization to use or disclose this Protected Health Information expires. I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to ***SPCS*** at 2016 Highway Blvd, PO Box 680, Spencer, Iowa 51301. I understand that a revocation is not effective to the extent that ***SPCS*** has relied on the use or disclosure of the Protected Health Information. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. **SPCS** will not condition my treatment, payment, or enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide Authorization for the requested use or disclosure. **I understand that I have the right to refuse to sign this Authorization.**

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative (PRINT)

____
Description of Personal Representative's Authority