Woodview Psychology Group, LLC
70 E. 91st Street, Suite 210, Indianapolis IN 46240

PATIENT REGISTRATION FORM – ADULT

PATIENT INFORMATION

Patient's Last Name:	First Name:	M.I.:	Nickname:		
Birth Date:	Age:	Gender:	Social Security #:		
Street Address:		City:		State	ZIP:
Home Phone:	Cell Phone:		Work Phone:		
Street Address:		City:		State	ZIP:
Employer:		Occupation:			
Physician:		Physician's Phone:			

FINANCIALLY RESPONSIBLE PARTY

Last Name:	First Name	M.I.:	Birth Date:	Social Security #:	
Relationship to Patient:					
Home Phone:	Cell Phone:		Work Phone:		
Street Address:		City:		State	ZIP:
Employer:		Occupation:			

CONSENT TO TREAT, PRIVACY POLICY

I hereby request and authorize Woodview Psychology Group, LLC (hereafter referred to as "Woodview Group" and its respective personnel to provide mental health services/treatment to me and any desired family members. I understand that mental health services/treatment may include and are not limited to assessment services including tests and procedures as well as therapeutic treatments, and that I am agreeing only to those services that Woodview Group is qualified to provide within the scope of the provider'(s) license, certification, and training or the scope of those provider(s) directly supervising the services received by me. I understand that with this consent, I give permission for aspects of my private healthcare information to be shared with Woodview Group, as is necessary for services to be provided. I understand that these services do not come with guarantees, that no guarantees have been given to me by Woodview Group, and that certain risks may be present in my participation in these services. I also understand that, at any time, I can terminate this consent for treatment by putting such request in writing.

I understand that communications within Woodview Group will be confidential. I understand that there are special circumstances that will require Woodview Group to break that confidentiality. By law, Woodview Group must report actual or suspected child or elder abuse to the appropriate authorities. In addition, Woodview Group is legally bound to take appropriate action if I threaten anyone with violence, harm, or dangerous actions. I am aware that I can ask further questions about confidentiality with any personnel.

I hereby acknowledge that I have been offered a copy of the 'Notice of Privacy Policies' and understand the information included in this document. I am aware that a copy of this notice will be given to me when I ask for a copy.

Patient's Signature: _____ Date: _____

FINANCIAL AGREEMENT

I understand that if I choose not to use my insurance benefits ("self pay") or if Woodview Group is not a participating provider with my insurance plan ("out of network"), I will pay in full, at the time of service, for all services rendered on my behalf. Woodview Group will provide a Billing Statement that I can file with my insurance provider for reimbursement.

I understand that if Woodview Group is a participating provider ("in network"), I will pay the co-pay at the time of service and Woodview Group will submit a claim to my insurance provider. I agree to provide accurate and updated healthcare/insurance information to Woodview Group and hereby give consent to Woodview Group to release any required information to my healthcare insurance to assist in the processing of claims, including protected healthcare information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). I also acknowledge and understand that I am responsible for any charges not covered by my health insurance.

I understand that if I have Medicaid, Medicare, or Tricare coverage, services provided at this office are non-Medicaid/Medicare or Tricare reimbursable, and I assume full financial responsibility for all services rendered.

I understand that 24 hours' notice of cancellation is required to avoid charges for missed appointments. I also understand that I may be charged a late fee if I arrive more than 15 minutes late to my appointment. I understand that missed appointment and late fees are not covered by insurance plans.

I also understand and agree to pay for any services related to legal matters, including but not limited to depositions, attorney phone calls, and court testimony; these services are a different pay rate.

Your signature acknowledges that you have read and agree to the Financial Agreement.

Patient's Signature: _____ Date: _____

AUTHORIZATION FOR MESSAGES

I authorize that telephone messages regarding my appointment times may be left on my (please initial Yes or No for each item):

Home answering machine/voicemail	_____Yes	_____No
Work voicemail	_____Yes	_____No
Cell phone	_____Yes	_____No

CONSENT TO USE EMAIL COMMUNICATIONS

I hereby agree to sending to and receiving from Woodview Group email communications as part of comprehensive treatment. I understand the risks of sending PHI through email, and with this agreement I am accepting these risks to my PHI. I accept that Woodview Group shall not be held responsible for any exposure of email communications at my home or place of employment, depending on the location of my email address. I also understand that email communications can fail in their transmission, and I agree to contact Woodview Group if I have not obtained a response from my email communication within three business days. I also agree to never use email communications for emergency situations, and to call the office directly with any emergencies. I understand that I can terminate this agreement at any time by informing Woodview Group in writing. With my signature, I believe that the benefits of using email communications for my healthcare outweigh the security risks.

Signature authorizing email communications:_____

Email Address: _____ (please print)