Amber Chan, LPC-MH, QMHP / Mindful DBT, LLC

PATIENT REGISTRATION SHEET

Today's Date:	**Please Print**	

PATIENT INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Street Address:	City:	State:	ZIP Code:

Home phone #: ( )	Cell/Other contact #: ( )	Social Security #:	Birth Date: / /	Sex: ❑ M ❑ F

Employer:	Occupation:	Work phone #: ( )

Street Address:	City:	State:	ZIP Code:

Referring Doctor (if required by insurance):	

Notify Primary Care Physician? ❑ YES ❑ NO	Name of Primary Care Physician	Contact #: ( )

IN CASE OF EMERGENCY

Emergency Contact Name:	Home phone #: ( )	Cell phone #: ( )

INSURANCE INFORMATION

Insured's Last Name **(if different):**	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home phone #: **(if different)** ( )	Cell/Other contact #: ( )	Social Security #:	Birth Date: / /	Sex: ❑ M ❑ F

Insurance Company:	Insurance Billing Address:	Insurance phone #: ( )

Policy #:	Group #:	Relationship to Insured:	❑ Self	❑ Spouse	❑ Dependent

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company:	Insurance Billing Address:	Insurance phone #: ( )

Policy #:	Group #:	Relationship to Insured:	❑ Self	❑ Spouse	❑ Dependent

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. *I understand that I am financially responsible for any balance.* I also authorize Amber Chan, LPC-MH, those acting on its behalf, and my insurance company to release any information required to process my claims.

Right to Refuse Treatment: I understand that I have the right to refuse any treatment.

Confidentiality: I understand that all information concerning me is held in confidence and can only be released with my written permission, with the following exceptions: my therapist is legally required to report to designated authorities when it is believed someone is a danger to themselves or others, including child/elder abuse/neglect, or as required by federal or state law. Your therapist may be involved in DBT Team Consultation as needed. To maintain your confidentially identifying information is removed.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

Patient/Guardian signature *Date*

*** PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations. Otherwise, your account may be charged $120.00 for the session time or $75.00 for DBT Groups.* Thank you for your cooperation.**