Doctor or therapist: Ron Artis Ph.D. **ADULT**

REGISTRATION INFORMATION

Please Print

CONFIDENTIAL

Name: _____ Today's Date: _____

Address: _____ City: _____ ST: _____ Zip: _____

Birthdate: _____ Gender: F M SSN: _____

Relationship Status: Single Married Domestic Partner Divorced Widowed Separated Other: _____

Your employer: _____ Job Title: _____

Spouse/Partner Name: _____ Birthdate: _____

Spouse/Partner Employer: _____ Work Phone: _____

CONTACT PREFERENCES

Phone (H): _____ (W): _____ (C): _____

___OK to leave message	___ OK to leave message	___ OK to leave message
___ with details	___ with details	___ with details
___ call back # only	___ call back # only	___ call back # only
___ NO message	___ NO message	___ NO message

Email: _____(confidentiality cannot be guaranteed for email communication)

Written Communication/Mail:

___ OK to mail to home address ___ OK to mail to work address: _____

Signature: _____ Date: _____

PRIMARY CARE PHYSICIAN Name: _____ Phone: _____

Address: _____ City: _____ ST: _____ Zip: _____

EMERGENCY INFORMATION In case of emergency, please notify: _____

Phone: _____ Relationship: _____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date Name of Personal Representative/Description of Authority

NOTIFICATON OF CHANGES I understand I am responsible for notifying the office of any change of address or phone number.

_____ _____

Signature of Patient or Personal Representative Date

Client Name: _____

Client Information (cont'd)

PAST AND PRESENT HISTORY

Put an (X) in the box which includes health/illness/condition history for you and your family.

	Good Health	Poor Health	Deceased	Depression	Suicide	Alcohol Abuse	Drug Abuse	Inattention	Psychosis	Severe Anxiety	Panic Attacks	Nervous Breakdown	Hospitalization for Mental Illness	Eating Disorder	Bipolar Disorder	Other
Patient																
Father																
Mother																
Brothers																
Sisters																
Spouse																
Children																
Mother's Mother																
Mother's Father																
Father's Mother																
Father's Father																

Client Name: _____

Registration Information (cont'd)

Medical Information:

Brief Medical History:

_____ Seizure Disorders	_____ HIV	_____ Migraines	_____ Developmental Delay
_____ Diabetes	_____ High BP	_____ M.S./M.D.	_____ Head Injury
_____ Heart Condition	_____ TB	_____ Polio	_____ Birth Trauma

_____ Other _____

_____

Current Medications and Dosage	Prescribing Doctor	Reason(s) for their use:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other persons living in the home:

Name	Relationship	How Long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

It there is any other information you would like us to know at this time, please continue on the reverse side and check here _____. Thank you for completing the registration information.

NOTICE OF PRIVACY PRACTICES

We at Austin Northwest Psychotherapy are committed to maintaining the confidentiality of your medical information. In most cases, your records will not be released without your written consent (which you can revoke). However, there are a few exceptions. We are permitted to disclose your medical information to other professionals involved in your treatment.

- We are permitted to use and disclose your medical information to your insurance company, if you choose to use them, or as required by worker's compensation law.
- We may disclose your medical information for public health concerns as mandated by federal or state government.
- We are required to report child abuse or neglect.
- We may release information if you are under the custody of law enforcement, or if ordered by the court.

You may request in writing that we restrict how your information is disclosed for treatment, payment or healthcare operations. Although we are not required to restrict this information, we will do so except in emergency situations.

It is our policy not to release information to family members or other individuals without your written consent. You have a right to access your health records with some limitations. You must submit your request in writing to the Privacy Officer.

Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or with the government. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You
We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests
If you have any questions or want to make a request pursuant to the rights described above, please contact Leir'dre Henton, Privacy Officer, at:

4131 Spicewood Springs Rd
Building D, Suite 8
Austin, TX 78759

This notice is effective September 17, 2018

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS.

_____ _____
Client Signature Date

_____
Print name

Revised: 10/2018

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_____ _____
Client Signature Date

_____
Print name

Revised: 10/2018

RON J. ARTIS, Ph.D., L.P.C., L.M.F.T.
STATEMENT OF UNDERSTANDING

Consent for Care:
I give full consent for the completion of my evaluation and provision of treatment as necessary, by the above named therapist, until otherwise notified. I understand that no promises have been made to me as to the result of treatment or procedures provided by this therapist. If I have any questions about the following information or about anything related to my therapy, I will discuss this with the therapist.

Confidentiality:
You have the right to confidentiality in your therapy. Information concerning your therapy will not be disclosed without your prior written permission except for the following legal exceptions:

1. Life or safety of you or someone else is seriously threatened.
2. There is good reason to believe that you are abusing or neglecting a child or vulnerable adult or if you give me information about someone else who is doing this, child/adult protective services and/or the appropriate law enforcement agency must be notified.
3. Court ordered.
4. An insurance benefit is filed and the claims payer requires information, i.e. diagnosis, types of treatment, dates, etc.
5. Parents or legal guardians of minors are legally privy to information disclosed during treatment. The therapist will discuss and clarify issues of privileged information regarding the child's treatment.

Emergencies/Telephone Counseling:
Psychiatric emergencies should be directed to 911 if life or safety is threatened. The office phone number, (512) 231-0164, is answered by staff during business hours and by a recording after hours.

Scheduling of appointments:
Please conscientiously keep all scheduled appointments. If it is necessary to cancel an appointment, you must give at least 24 hours notice. Monday appointments must be canceled before noon on the preceding Friday. **You will be charged a fee for missed appointments or appointments canceled without 24 hours advanced notice (see fee schedule).** Insurance companies do not pay for missed appointments.

Fee policy:
While the filing of insurance claims is a courtesy that is extended to you, all charges are ultimately your responsibility for the date of service. All co-payments, unmet deductible expenses, and services or charges not covered by insurance are due at the time of service. Any returned checks are subject to a $25 charge. Should your account be referred for collection, you agree to pay 6% interest plus a $25 collection fee and reasonable attorney fees and/or court costs.

Fees for services:
Individual psychotherapy (50 min) = $140.00
Marital/Family psychotherapy (50 min) = $150.00
Review of records = $35.00/15 min.
Court Appearance due to subpoena = $220.00/hour
(door to door, paid in advance, **48 hour notice)**
Fees for other services provided upon request

Missed appointment = **full fee**
Telephone consultation = $35.00/15min.
Emergency calls = $45.00/15min.
Release of records = $25.00 to $50.00
Telephone consultation w/attorney = $35.00/15 min.
Deposition/Court Appearance = $220/hour
(door to door, paid in advance, one week notice)

I work with a group of independent mental health professionals, under the name of Austin Northwest Psychotherapy. This group is an association of independently practicing professionals who share certain expenses and administrative functions. While members share a name and office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS.

_____ _____
Client Signature Date

_____
Print name

Revised: 10/2018

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Fees for services:
Individual psychotherapy (50 min) = $140.00
Individual psychotherapy (1 hour 30 min) = $280.00
Marital/Family psychotherapy (50 min) = $150.00
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PATIENT COPY

_____ _____
Client Signature Date

_____
Print name

Revised: 10/2018

CREDIT CARD FORM

Patient Name: _____

Clinician/Doctor Name: _____

Card holder's First Name: _____

Middle Initial: _____

Last Name: _____

Billing Address: _____

City: _____

State: _____

Zip Code: _____

*Phone Number: _____

*Email Address: _____

Type Card: VISA or MASTERCARD (PLEASE CIRCLE ONE)

Card Number: _____

Expiration Date: _____

CVS #: _____

Amount Charged: _____

Card Holder's Signature: _____