### Patient Registration Form

###### Preferred Name:

**Pronouns:**

**Which of the following best describes your gender?**

Woman Transgender Woman Gender Queer

Man Transgender Man Other:

###### Legal Last Name: Legal First Name: Social Security #: Birth Date: Your assigned sex at birth: Female Male

**Street Address: Apt/Unit #: City, State, Zip: Mailing Address (if you cannot get mail where you live):**

**Phone Number (to be used for reminder calls/text messages for appointment reminders, provider calls, etc):**

**Email Address**:\_

###### Emergency Contact (Name/Relationship/Phone number)

**If we need to reach you and we are unable to do so by phone, how should we contact you? Please write email or numbers we can contact:**

**How do you identify your Race(s)? What is your preferred spoken language?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you need an interpreter for** | **your visit?** |  | Yes | No |
| **Are you Hispanic or Latino? Are you currently homeless?** | Yes Yes | No No |  |  |

If yes, where are you living? Street Doubling Up Shelter Transitional

###### How did you hear about Face to Face?

**Are you interested in information on any of the additional services listed below and offered by Face to Face**?

**SafeZone Mental Health Insurance Other:**

**Income Information (report only the patient’s income)**

By signing below I hereby give my permission to Face to Face to allow review of my financial information for the purpose of reporting to funders on general income levels. Specific information will not be shared. This will not release any records or information of why you are here.

I certify that the information on this form is accurate and complete. I authorize Face to Face to verify information provided if necessary.

Check all the types of income below you receive ***each month*** and the amount you receive:

* None
* Employment (Job) Amount: per month
* Social Security Disability(SSI) Amount: per month
* MFIP Amount: per month
* General Assistance Amount: per month
* Other Amount: per month Are you married? Yes No

Do you have children? Yes No How many children do you have?

### Payment Authorization

Face to Face serves everyone, regarding of an individual’s income, insurance status, or ability to pay. For patients that are self-pay, we charge based on a sliding scale. We are happy to work out payment plans and we are committed to meeting the healthcare needs of everyone. If my insurance denies any part of my claims, I hereby agree to pay for my services on a sliding fee scale.

By signing below I authorize Face to Face Health and Counseling Service Inc. to release any information concerning my health care to my insurance company. I hereby authorize payment of the amount due for any pending insurance claim be made directly to Face to Face Health and Counseling Service Inc. Payment is authorized upon your receipt of an itemized statement of services. \*I un derstand that if I am covere d un der m y p arents ’ po lic y and want F ace to F ace He alth an d Counseling Service Inc. to bill my insurance company, my parents may receive a copy of the charges

### Rights, Responsibilities, Privacy and Electronic Communication

\*There is a copy of our Rights, Responsibilities, Privacy & Electronic Communication notice available at the front desk, and on our website: [www.face2face.org](http://www.face2face.org/)\*

By signing below you also indicate that you have been given a copy of Face to Face Health and Counseling Service Inc. Rights, Responsibilities, Privacy and Electronic Communication notice today or at a previous visit, and understand that it provides information about how Face to Face Health and Counseling Service Inc. may use or disclose protected health information.

I understand that I may request a copy to retain for my own records at any time in the clinic. This Authorization is valid for one year unless I cancel by giving written notice to Face to Face Health and Counseling Service Inc. or it expires as required by law.

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Legal Guardian Signature: |  | | Date: |  |
| (required if client is under 18 | |  | | |

### Consent

I hereby authorize and give my expressed consent to Face to Face Health and Counseling, Inc. for medical treatment of minor illness or injuries, vaccinations, testing, treatment and routine health maintenance for:

(client’s first and last name)

as deemed necessary by the professional medical staff. This staff includes medical assistants, registered nurses, nurse practitioners, and, physicians.

I authorize **MEDICAL CARE** for above named client at Face to Face Health and Counseling Service Inc.

###### (Please check yes or no)

**YES NO**

I hereby authorize and give my expressed consent to Face to Face Health and Counseling, Inc. for the administration of

mental health treatment, including counseling services and assessment, as well as coordination of services for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (client first/last name) as deemed beneficial or necessary by professional mental health staff including graduate clinical interns, mental health practitioners and licensed mental health professionals. I understand that my provider may be supervised by a licensed mental health professional for supervision and insurance billing purposes. I understand that my mental health provider will consult with the mental health team as deemed necessary. I further understand I can contact Mental Health Manager: Sue Rau LICSW or Katie Harrold, LMFT with any additional questions or concerns regarding this.

I authorize **MENTAL HEALTH CARE** for above named client at Face to Face Health and Counseling Service Inc.

###### (Please check yes or no)

**YES NO**

I accept responsibility for understanding the content of this document. My signature below constitutes my acknowledgement:

1. That I have read and agree to the above.
2. That I hereby give my authorization and consent to treatment and/or consultation for the above named client to receive routine medical care and, mental health care to my child unless checked NO above.

I understand that this consent will last for one year unless I change my mind and withdraw by consent sooner in writing. If I withdraw consent, it will not affect actions already taken by authorized person.

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Date: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Legal Guardian Signature: |  | | Date: |  |
| (required if client is under 18) | |  | | |

### WELCOME TO FACE TO FACE!

###### Face to Face Health and Counseling Service, Inc. will maintain your privacy and confidentiality. The confidentiality of this and other forms you complete here is protected by Federal laws and regulations. You are not required to answer the questions in this form. The questions are being asked so Face to Face can give you the best service possible

**Date:**

**Legal Name: Preferred Name:**

**Parent/Guardian first, last name and email address (if client is under 18)**

**Are you attracted to: (check all that apply)** Males Females Both Neither Unsure

###### What language is spoken in your home?

**Do you speak another language?** Yes No If “yes”, which language(s)?\_

###### Have you ever been pregnant? Yes No Are pregnant or a parent to be? Yes No

**Are you a parent? Y**es No **If yes, Child/Children names and ages:\_**

**Do you receive other services with us?**

SafeZone Medical Clinic Connect Prenatal Program/Case Management Health Education Insurance

**Where are you living?** (Please check all that apply):

Parent(s)’ home Relative’s home Friend’s house Group home Shelter

**How long can you live there?** Less than a week A month or more Permanently Unknown

###### Do you feel safe where you live? Yes No

**Names and ages of your siblings:**

**What/Who are the support system(s) in your life?** (Please check all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
| Family/Relative | Friends | School | Other: explain |
| Sports  Partner | Art/Music  Youth Group | Church  Community Group |  |

**Are you currently in school?** Yes No If Yes, where? What Grade?

**Do you have a job?** Yes No If Yes, Where? How Many Hours Per Week?\_

**How would you rate your current physical health?** Excellent Good Fair Poor

**Are you taking any medications?** Yes No If “yes”, what and what for?

**Have you ever had suicidal thoughts?** Yes No **Have you ever tried to hurt yourself?** Yes No

###### Has anyone ever tried to hurt you physically or in any way? (ex, kicking, slapping, biting etc.) Yes No

**Have you been involved, or witnessed, any violence in the last year? If “Yes” where?**

At Home At School In the Community Other:\_

###### Are you in a relationship with a person who threatens or physically hurts you? Yes No

**Has anyone forced you to have sexual activities that made you feel uncomfortable?** Yes No

**Has anyone emotionally and/or verbally abused you?** Yes No

**Have you ever been neglected? Yes No**

**Substance Use**

Do you drink alcohol? Yes No If yes, age of first use\_ How much do you drink?

How often do you drink?\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What substances have you used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you done things you’ve regretted because of substance use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you noticed a need to use more of a substance to get the desired effect? Yes No

**CAGE-AID Chemical Health Assessment**:

1. Have you ever felt that you ought to cut down on your drinking or drug use? Yes No
2. Have people annoyed you by criticizing your drinking or drug use? Yes No
3. Have you ever felt bad or guilty about your drinking or drug use? Yes No
4. Have you ever had a drink or used drugs first thing in the morning (eye-opener) to steady your nerves, get rid of a hangover, or get the day started? Yes No

###### What is your main reason for coming to counseling today?

**What life changes or stressful events have been going on lately?**

**IF APPLICABLE: To Parents/Guardians: What goals do you have for your child in therapy?**

**What days and times would you prefer to have counseling appointments? List three words that describe your life right now:**

**Please circle any symptoms or experiences that you have had in the past six months**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sadness/tearfulness | Feeling down or depressed | Panic Attacks | Feelings of nervousness, tension or anxious | Worrying all the time | Racing thoughts |
| Skipping school | Staying out late | Sleeping too much, | Sleeping too little | Trouble Falling Asleep | Trouble Staying Asleep |
| Acting out sexually, | Being unhappy during or after sex | Trouble concentrating | Easily distracted | Poor attention | School Anxiety |
| Eating more often | Eating less often | Not feeling hungry | Under eating | Binge Eating | Making yourself vomit |
| Worried about weight:  (too much weight or not enough) | Spending increased time alone | Social Anxiety | Self-Harming | Angry Often | Anger outbursts |
| Relationship stress with significant other/partner | Separation or divorce | Feeling Numb or Nothing | Feelings of loneliness | Low self-esteem/ low confidence | Getting into fights/arguing often |
| Loss of interest in previously enjoyed activities | Feeling or acting like a different person | Difficulty leaving your home | Mood swings | Repetitive behaviors (e.g. frequent checking, hand washing | Feeling hopeless and/ or helpless |
| Gender identity | Family problems | Trouble with Memory | Being tired during the day | Flashbacks | Hearing things that are not there |
| Sexual identity | Nightmares/ sleepwalking | Suicidal thoughts/ feelings | Thoughts or actual self-harm | Being abused | Seeing things that are not there |
| Issues with peers/friendships | Low Impulse Control | Finances | Being Bullied | Job/Work/Career | Perfectionism |
| Making/keeping friends | Pregnancy | Parenting | Troubled about future plans | Thoughts about harming or killing someone else | Fire setting |
| Feelings of guilt | Unresolved grief/loss | Worried about a place to live | Religious/ spiritual concerns | Stealing | Other: |

#### Your Rights:

**Rights, Responsibilities, Privacy, and Electronic Communication**

* + Respect, dignity, confidentiality and privacy
  + Request and receive a copy of your medical record
  + Request another provider, or to get a referral to another agency
  + Know that your service provider may consult with other Face to Face service providers including mental health, medical, health education and SafeZone staff to best serve your needs
  + To informed participation in decisions involving your health care
  + To a safe environment with suitable privacy
  + To refuse treatment and be informed of the medical consequences of refusal
  + To expect reasonable education regarding treatment options and prescribed treatment programs

**Your Responsibilities:**

* + Be honest about what you need
  + Respect the privacy of other clients
  + Inform staff of complaints or problems
  + Informing your provider if you do not understand the instructions or explanations given to you
  + Provide your current and accurate health information at each visit
  + Informing your healthcare provider if instructions cannot be followed and a more suitable plan is required
  + Treating all Face to Face staff respect
  + Cooperating in observing safety regulations and policies in the office

**Your Privacy:**

Face to Face Health and Counseling Services, Inc. will maintain your privacy and confidentiality. The confidentiality of this and other forms completed here is protected by federal laws and regulations.

Face to Face Health and Counseling Services, Inc. cannot disclose that a client receives services or any other information on a client unless:

* + The client consents in writing
  + The disclosure is allowed by court order
  + Disclosure is to medical personnel in an medical emergency
  + Disclosure is allowed for audit or for evaluation purposes,
  + As otherwise allowed under HIPPA (Health Insurance Portability and Accountability Act)

Some exceptions to confidentiality under the law, which may require the provider to release information, include but are not limited to:

* + Knowledge of or reasonable cause to believe that a child is being neglected, emotionally, physically or sexually abused
  + Clients who are 16 and under who are victims of a crime
  + Maltreatment of a vulnerable adult as specified in the Vulnerable Adult Act
  + Person is a harm to themselves or others

### Electronic Communication:

* + E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients. E-mail and other forms of electronic communication are not “secure” means of communication.
  + Backup copies of e-mail or text messages may exist even after the sender or the recipient has deleted his/her copy.
  + All e-mail and text messages may be discoverable in litigation regardless of whether it is in a patient’s medical record.
  + Messages transmitted via e-mail may not be picked up in a timely fashion. To avoid unnecessary delays in the transmission of important information, do not use e-mail to send urgent messages.

**EMAIL COMMUNICATION** I (we) understand the assumptions stated above and understand that e-mail is not a secure means of communication. I am aware that the provider may decline to communicate via e-mail based upon the nature of the medical information. I give permission Face to Face Health & Counseling Service, Inc. to use electronic mail as a means of communication regarding my care. I understand that I may withdraw this authorization at any time by notifying Face to Face Health and Counseling Inc. administrative staff or my provider in writing.

**TEXT MESSAGING** I (we) understand the assumptions stated above and understand that text messaging is not a secure means of communication. I am aware that the provider may decline to communicate via text messaging based upon the nature of the medical information. I give permission for Face to Face Health and Counseling, Inc. to use text messaging as a means of communication both between myself regarding appointment reminders, scheduling and reminders regarding paperwork, or for client or guardian(if applicable) to call the clinic. I understand that I may withdraw this authorization at any time by notifying Face to Face Health and Counseling administrative staff or my provider in writing.