Client Registration Form

Last Name:_____First Name:_____MI:___

Address:_____

Preferred phone #:_____ Date of Birth:_____

Gender: M / F / non-binary Preferred pronoun:_____

Partner Status: Single / Married / non-binary Religion/Faith:_____

Occupation/Employer:_____

Emergency Contact:_____Phone: _____

Preferred Emergency Room/Hospital:_____

Have you had previous psychological consultations/treatments? Y N If yes, when:_____

How did you first hear of Valentine Counseling Services:_____

Terms and Conditions of Service

Notice of Privacy Practice and Disclosure of Information:
I have received a copy of the Notice of Privacy Practices for Protected Health Information.

I understand that my health information (including mental health information) may be disclosed for the purposes of treatment, for obtaining payment from my insurance carriers, and/or to other qualified health care professionals, with my written authorization, within limits of the law.

I understand that according to Minnesota law, I may choose to pay for services if I do not wish my health information to be given to my insurance company. I agree to notify this office about my wishes regarding payment and I understand that if I fail to pay for the services, the information will be sent to my insurance carrier.

Cancellations:
For self-pay or non-state funded insurance, $50 charge for late cancellations (appointments cancelled with less than 24 hours' notice) or no-shows, which must be paid before scheduling future appointments
For state-funded insurance, 2 no-shows may result in referrals to other providers

Nondiscrimination Policy:
This facility will treat clients within its capabilities, regardless of race, national origin, religious belief, gender, sexual orientation, marital status, age, veteran's status, political beliefs, or disability.

Communications:
Check ALL items that apply to you. *Non-urgent* results, confirmation, and general information / instructions regarding your health care can be left on:
____A message at my preferred number
____Preferred phone voicemail / text message
____Email (circle: work / personal) _____
____Do NOT leave any messages on my home, work or cell phone

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Information regarding non-urgent results confirmation and general information / instructions regarding my health care can be shared with and via the following:

____Spouse / Significant Other (name)_____

____Other - specify relationship / name(s)_____

____Email address_____

____Text messages – preferred #_____

_____
Signature

_____ _____
Print Name Date/Time

_____
Signature

_____ _____
Print Name Date/Time