Please provide your photo ID and insurance card for us to copy

Sothia L. Green, Psy.D., LCADC
Transformations Counseling and Substance Abuse Services

PLEASE PRINT Patient Registration Information

LAST NAME	FIRST NAME	MIDDLE INITIAL

DOB - MM/DD/YYYY	AGE	GENDER	SSN
		☐Male ☐Female ☐Other	

MARITAL STATUS

☐Single ☐Married, living together ☐Married, not living together ☐Cohabiting with Partner ☐Separated
☐Divorced ☐Widowed ☐Other, explain:

EMPLOYMENT/STUDENT STATUS *(check on from each category, if applicable)*

Employment Status		Student Status
☐Unemployed, not looking for work	☐Unemployed, looking for work	☐Part-Time
☐FT employed ☐PT employed	☐Retired	☐Full-Time
☐On Welfare ☐Soc Sec Disability	☐Self-Employed	☐Not a student

Employer Name, if employed:	

HOME ADDRESS

Street Address *(apt #, if applicable)*	City, State & Zip code

CONTACT INFORMATION

Home Phone	**Work Phone**	**Cell Phone**

Email(s)	Preferred Method of Communication
1)	☐ Home Phone ☐Work Phone ☐Cell Phone
2)	Would you like to receive appointment reminders via email or text? ☐Yes ☐No

Please give us your insurance card(s) to copy for your file

INSURANCE INFORMATION ***if not using insurance, skip to responsible party section***

Insurance Company Name	Policy/Plan Number	Group Number

If using an EAP (Employee Assistance Plan), Please indicate the EAP info	EAP Carrier Name:	# of Approved EAP Visits:	EAP Auth Dates: Start:
	EAP Approval Code:		End:

RESPONSIBLE PARTY ☐Same as Patient

This Is the person that is responsible for any unpaid balances (copays, coinsurance and/or deductibles)

Name:		Relationship to Patient: ☐Mother ☐Father ☐Guardian ☐Other, explain
DOB:	SS#	Address ☐ *check here if same as patient*

Authorization and Assignment: I authorize the release of medical information necessary to process this and all claims to my insurance company, including Medicare and Medicaid. I request benefits be made payable to **Sothia L. Green, Psy.D., LCADC**. I acknowledge that I am financially responsible for this and all claims whether or not paid or covered by my insurance company or other organization. I also agree that if my account is referred to a third party for 60 days past due, I will be responsible for the collection agency fee of 35% plus 19% interest and the balance due. *You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us. Methods of contact may include using pre-recorded or artificial voice messages and/or the use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that Sothia L. Green, Psy.D., LCADC or representative may contact me/us as described above.*

⊗ _____ _____

Signature of Patient (Parent/Guardian if minor child) Date

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Transformations, LLC for all services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

_____ _____

Signature Date

Medicare Patients

If you are covered by Medicare, please read and sign the following:

In Medicare cases, Transformations, LLC agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

_____ _____

Signature Date

Financial Policy

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account. We ask that you remit any applicable copay, deductible, and co-insurance according to the terms of your insurance contract at the time services are rendered. Furthermore, if you do not pay your copay at the time of your appointment, we retain the right to levy an administrative charge of $20. Additionally, it is your responsibility to provide any necessary referral information to us, that your insurance requires prior to your visit.

If you do have an outstanding balance due, we appreciate prompt payment in full. If you are unable to make payment in full, please inquire about arranging a payment plan. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due to a collection agency. In addition to the principal balance due, you will also be responsible for any legal or collection agency fees incurred. Any payment made to us in the form of a check that is returned for insufficient funds will incur a $50 fee per incidence.

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Cancellation Policies

If you fail to provide us with a 24 hour notice of cancellation or fail to keep your scheduled appointment, we reserve the right to charge you a $30 no show fee.

Consent

My signature below indicates my full understanding and consent to the above described policies. Additionally, I provide authorization to my insurance company to pay any applicable benefits directly to Transformations, LLC.

_____ _____
Patient signature Date

_____ _____
Guarantor signature (if guarantor is not patient) Date

Acknowledgment of Notice of Privacy Practices and Permission of Disclosure

I acknowledge that I was made aware of Transformations LLC's Privacy Policy and a copy was available for my review.
I authorize the following person(s) access to my protected health information (PHI).

Name Date of Birth

_____ _____
_____ _____
_____ _____
_____ _____

Patient Printed Name Date

_____
Patient Signature

_____ _____
Printed Name of Personal Representative Signature of Personal Representative

_____
Relationship of Personal Representative to Patient

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Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below indicates that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

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TRANSFORMATIONS, LLC

Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking

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❑ Legal matters, charges, suits
❑ Loneliness
❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Memory problems
❑ Menstrual problems, PMS, menopause
❑ Mood swings
❑ Motivation, laziness
❑ Nervousness, tension
❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection
❑ Pain, chronic
❑ Panic or anxiety attacks
❑ Parenting, child management, single parenthood
❑ Perfectionism
❑ Pessimism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems (with friends, with relatives, or at work)
❑ School problems (see also "Career concerns ...")
❑ Self-centeredness
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suspiciousness, distrust
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance
❑ Thought disorganization and confusion
❑ Threats, violence
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
❑ Other concerns or issues:

_____
_____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

_____
_____

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