Family Wellness Associates

New Client Registration Form

First Name:	Preferred Name:	Date:
Middle Initial:	Last Name:	
Birth Date:	SSN:	Gender: M / F
Address:		Marital Status: Single / Married / Other
City/ State/ Zip Code:		Employed: Yes / No / Other
If minor, parent / guardian name: _____		DOB: _____
Phone Number:	Address:	

Phone	Number	Okay to call	Okay to leave a voice mail/text message
Cell		☐	☐
Home		☐	☐
Text		☐	☐

Others in the household:

Name	Relationship	Date of Birth

Is there anyone you would like contacted in case of an emergency? (Optional)
NEED RELEASE Signed for ER contacts.
Name:_____Relationship:_____Phone Number: _____

Insurance Carrier (s): _____ **Policy Number (s):** _____

Policy Holder Name: _____**Relationship to Patient:** _____

Policy Holder DOB: _____**Policy Holder Phone Number:** _____

Policy Holder Address: _____

Family Wellness Associates

Informed Consent for HCBS Waiver

I certify that I have read, understand and agree to abide by the information, terms and conditions contained in this Informed Consent for services form. I have had the opportunity to discuss any questions about the information contained in this form, or any other aspect of Family Wellness Associates. I hereby give my consent to Family Wellness Associates for Service(s) being provided.

Check all that apply:

☐ **Assessment**
☐ **Therapy**
☐ **BHIS**
☐ **HCBS Waiver**
☐ **Substance Treatment**
☐ **DUI/OWI**

I understand the following: (Please INITIAL):

_____ Informed Consent for treatment has been made available to me.
_____It has been fully explained to me about the nature of the treatment, the risks and benefits, and the available treatment options.
_____I have had the opportunity to have all questions answered to my satisfaction.
_____That this consent is given voluntarily.
_____I am legally competent and have the authority to provide consent for treatment.
_____I have the right to withdraw my consent for this treatment at any time.
_____I also understand that, if at any time, I wish to review my records.
_____ I have received the Mental Health Advance Directive Information Sheet.
_____I understand the attendance and cancellation policy

_____ _____
Client Signature Date

TREATMENT PERMISSION FOR CHILD/ADOLESCENT

Name of child/adolescent: _____

It is the policy of Family Wellness Associates to require the permission from parents/guardians before treating children or adolescents. I hereby give my permission to the Family Wellness Associates mental health therapist to provide to said child/adolescent such diagnostic and treatment services as found indicated by the professional staff.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date

Name: DOB: Medicaid:

Family Wellness Associates

PRE-DISCHARGE SUMMARY/TREATMENT PLAN/ CRISIS PLAN DEVELOPMENT

Start Date: _____ **End Date:** _____

_____By initialing, I acknowledge that I was involved in the development of my pre-discharge plan and acknowledge that at any time during the course of treatment I can review my pre-discharge plan with my provider. I understand that the pre-discharge summary was developed specifically for my treatment.

_____By initialing, I acknowledge that I was involved in the development of my treatment plan and acknowledge that at any time during the course of treatment I can review my treatment plan with my provider. I understand that treatment goals were developed specifically for my treatment.

_____By initialing, I acknowledge that I was involved in the development of my crisis plan and acknowledge that at any time during the course of treatment I can review as well as suggest modifications with my provider. I understand that the crisis plan was developed specifically for my treatment.

_____ _____
Signature of Client Date

_____ _____
Signature of Guardian (if applicable) Date

_____ _____
Signature of Provider Date

Notice of Privacy Practices

Receipt and Acknowledgment of Notice
I hereby acknowledge that I have received and have been given an opportunity to read a copy of Family Wellness Associates' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact 712-255-0890 for assistance.
❑ Patient/Client Refuses to Acknowledge Receipt:

_____ _____
Signature of Client (parent/Guardian) Date

_____ _____
Witness Date

Name: DOB: Medicaid:

Family Wellness Associates

MEDICATION CONSENT FORM

Prescribing Provider or Representative, _____ has educated me regarding the medication that has been prescribed for me. I have been educated regarding the possible side effects of this medication. I have also been informed of the reason this medication has been prescribed. If the person for whom the medication has been prescribed is under the age of eighteen (18) or is unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or am legally authorized to initiate and consent to treatment on behalf of this person. I understand that Family Wellness Associates does not provide or dispense medication before, during, or after services.

Name of Medication	Daily Dosage	Authorizing Physician

Signature: _____ Date: _____

Financial obligation/Insurance

Family Wellness Associates Inc. will submit payment to your private party insurance in a timely manner. It is the expectation of Family Wellness Associates Inc. That all clients bring their ID card to their first session in order for a copy to be made for our records. If you have more then one insurance policy, it is your responsibility to inform your counselor and provider both insurance cards at the session and indicate which is primary. If any changes are made regarding your insurance carries throughout your course of treatment (i.e., coverage is dropped, coverage is changes to a new company), it is your responsibility to inform Family Wellness Associates Inc. immediately of these changes. You should contact your health insurance company or consult with your therapist for additional information. Family Wellness Associates Inc. has the right to place services on hold or refer you to another agency if your outstanding co-insurance/deductible balances reaches $100 or your outstanding balance reaches $250.

Each client is responsible for payment for services rendered on the day of the appointment.

Since we reserve your appointment time for you, there will be a charge for any appointments missed or not canceled within 24 hours of your appointment time. Insurance does not cover the Late Cancel/ No Show fee, which means that it is essentials for you to cancel your appointment at least 24 hours in advance to avoid this charge.

I have reviewed and acknowledged the expectations regarding billing my private insurance company and my responsibility regarding any outstanding billing.

If your check is returned from the bank as dishonored, a $35.00 return check fee will apply.

I, _____ have reviewed and acknowledged the expectations regarding billing my private insurance company and my responsibility regarding any outstanding billing.

_____ _____

Client/Guardian Signature Date

Name: DOB: Medicaid: