

# Clare M. Rountree, Ph.D., LLC

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## Registration Form

Client's Name \_\_\_\_\_ Date \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_  
Employer:/School: \_\_\_\_\_ Emp.Address \_\_\_\_\_

***Please complete the following section if client is a minor:***

If the client is a minor, his/her **legal guardian** must sign this registration form, the consent for treatment form, and all other forms required for clinic services.

Legal Guardian's Name \_\_\_\_\_ Relationship to Minor \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_  
Mailing Address \_\_\_\_\_

If the minor's legal guardian is CPS/DHS or another state, federal, or private agency: Name of assigned worker/agency \_\_\_\_\_ Phone # \_\_\_\_\_

*I have completed the above information to the best of my knowledge. I will notify you of any changes in my health/minor child's health status or in any of the above information. My signature below also authorizes the release of information to my insurance company which is necessary to process insurance claims.*

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_  
(Print)

Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_  
(Signature)

**Background Information:**

Please state your reason(s) for seeking behavioral health services at this time.

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How were you referred to us?

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Have you previously received behavioral health services? Please include the name of provider seen and approximate dates of services.

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Who is your Primary Care Physician? \_\_\_\_\_

Last Physical Examination and Significant Findings? \_\_\_\_\_

Have you informed your Primary Care Physician of your/your child's behavioral health concerns? Yes\_\_\_\_\_ No\_\_\_\_\_

Are you/your child taking any medications now? \_\_\_\_\_ If yes, please list all medications and supplements taken.

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Please complete all history items below that apply to you/your child.

Hospitalizations:\_\_\_\_\_

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Serious or Frequent Illnesses:\_\_\_\_\_

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Childhood Illnesses: \_\_\_\_\_

Allergies: \_\_\_\_\_

Head Injuries: \_\_\_\_\_

Seizures: \_\_\_\_\_

Previous Mental Health treatment? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider? \_\_\_\_\_ Diagnosis Treated \_\_\_\_\_

***Financial Agreement:***

\_\_\_\_ I understand that individual sessions are 50 minutes.

\_\_\_\_ I understand and agree that regardless of my insurance status, I am responsible for any balance on my account for services rendered.

\_\_\_\_ I understand that fees and charges are due on the date of services rendered.

My Insurance carrier is \_\_\_\_\_

My Insurance Number is \_\_\_\_\_

\_\_\_\_ I agree to pay at each session.

\_\_\_\_ I agree to pay according to my annual salary:

√ Check one	Annual Salary (Combined household)	Individual Counseling (50 Min)	Family Counseling (50min)	Family Counseling (110min)	Group (per session)	Functional Behavioral Assessment (per hour)
	\$40,000	\$90.00	\$100.00	\$160.00	\$50.00	
	\$60,000	\$100.00	\$115.00	\$180.00	\$75.00	
	\$80,000>	\$150.00	\$175.00	\$225.00	\$85.00	

\_\_\_\_ I agree that I will be fiscally responsible for all sessions that I do not cancel before 24 hours of the scheduled appointment time.

Client Name \_\_\_\_\_

Client Signature \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_