REGISTRATION FORM **Kari Hunter, LCPC, LMFT**

Patient Information

Today's Date: ______________

Name:____ Date of Birth: __ __ /__ __/__ __ __ __

Address:____City:_______________State:_________Zip_______________

Home Phone (______)_____________Work Phone (_____) ________________ Cell Phone (______)__________________

Please contact me on my: ☐ Home phone ☐ Work phone ☐ Cell phone. OK to leave a message? ☐ Yes ☐ No

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Remarried ☐ Cohabitating

If patient is a student, Name of School______________________________ City ________ Grade level:________

If patient is employed, occupation and employer:___________________________________

If patient is a minor please complete the following:

Mother's Name:______________________________________ Date of Birth: __ __ /__ __/__ __ __ __

Address (if different than above): _______________________________City:_______________State:______Zip_________

Home Phone (______)_____________Work Phone (_____) ________________ Cell Phone (______)__________________

Please contact me on my: ☐ Home phone ☐ Work phone ☐ Cell phone. OK to leave a message? ☐ Yes ☐ No

Check Appropriate Box ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Remarried ☐ Cohabitating

Occupation/employer___________________________

Father's Name:______________________________________ Date of Birth: __ __ /__ __/__ __ __ __

Address (if different than above): _______________________________City:_______________State:______Zip_________

Home Phone (______)_____________Work Phone (_____) ________________ Cell Phone (______)__________________

Please contact me on my: ☐ Home phone ☐ Work phone ☐ Cell phone. OK to leave a message? ☐ Yes ☐ No

Check Appropriate Box ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Remarried ☐ Cohabitating

Occupation/employer___________________________

Patient information continued:

I was referred by ____

In case of an emergency contact: _____________________________________ Phone__________________________

Do you wish to use secure email for communications about billing, appointment setting, etc.? ☐ Yes ☐ No

Email Address____

Who else is in the immediate family/household?

Name	Age	Relationship to Patient	Comments/Concerns

Kari Hunter, LCPC, LMFT

Patient Name________________________________

Patient Medical Information

Who is your primary care physician? ____________________________ Address/Phone: _____________________________

Other than the reason for today's visit, do you have any other medical conditions? ☐ Yes ☐ No

If yes, please list : ____

Please list any medications with dosage:____

Please identify any known allergies: ____

Previous counseling/psychiatric treatment/psychotherapy:

	When	Name of Provider /Address or Location	Problem Addressed
1.	________	____	___________________________
2.	________	____	___________________________
3.	________	____	___________________________

Is there a family history of mental illness, depression, anxiety, or alcohol or drug abuse? ☐ Yes ☐ No

	If yes, who/ what was the relationship to patient?	Name of Provider /Address or Location	Problem Addressed
1.	________	____	______________________
2.	________	____	______________________
3.	________	____	______________________

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:____

Address (if different than patient/or parents listed on previous page):____

City:________________________________ State:__________ Zip:_____________ Phone: (____)_____________________

Employer_________________________ Work Phone (____)__________________ SSN#_____________________________

☐ **I will be using insurance** and have provided the necessary insurance information including any pre-authorization required by my insurance company. I am requesting that Kari Hunter submit claims to my insurance on my and/or the patient's behalf. I agree to assignment of benefits to Kari Hunter, LCPC, LMFT and agree to be responsible for any co-payment, coinsurance, and deductible not covered by my insurance. I give my permission for Kari Hunter, LCPC, LMFT to submit the necessary information to my insurance company as indicated by my signature below. I also agree to pay for any services that are not payable by insurance but are incurred as a product of my (or the patient's) treatment and counseling (e.g., phone calls, reports, letters to other providers, etc.). This includes a fee incurred when I fail to cancel an appointment without 24hr notice.

☐ **I will not be using insurance and will be paying for all services out-of-pocket.** I agree to pay for my therapy appointments and any services that are incurred as a product of my (or the patient's) treatment and counseling (e.g., phone calls, reports, letters to other providers, etc.).

Print name: __________________________________ Signature: ________________________________ Date: __________

Consent to Treatment and Privacy Notice

I have been provided with a copy of ***What You Should Know About Psychotherapy and The Policies and Practices Used to Protect the Privacy of Your Health Information (HPPA).*** I agree to the terms described by Kari Hunter, LCPC as a condition of treatment and I consent to receive psychotherapy treatment for myself and/or that of my minor child.

PRINT NAME: _________________________ Signature of patient (age 14 or older):_______________________ Date: __________

PRINT PARENT NAME: _____________________ Signature of Parent: _____________________________ Date: __________