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Soul Care and Wisdom Guidance

REGISTRATION FORM FOR A CHILD

PATIENT'S FULL NAME ______________________________

AGE ______ DATE OF BIRTH ______________________ MALE ________FEMALE ________

STREET ADDRESS ______________________________

CITY ______________________________ STATE __________ ZIP CODE __________________

HOME PHONE # ________________________WORK PHONE # ____________________________

CELL PHONE # ________________ BEST NUMBER TO REACH YOU ____________________

FAMILY PHYSICIAN'S NAME ______________________________

FAMILY PHYSICIAN'S PHONE / CITY ______________________________

NAME OF PERSON OR AGENCY WHO REFERRED YOU TO US ________________________

CHILD'S SOCIAL SECURITY NUMBER ______________________________

WHO HAS CUSTODY OF THIS CHILD? ______________________________

MOTHER'S NAME ______________________________

MOTHER'S ADDRESS ______________________________

MOTHER'S PHONE INFORMATION:

HOME ____________________WORK ____________________CELL ______________________

PLACE OF EMPLOYMENT ______________________________

ADDRESS OF EMPLOYER ______________________________

____

OCCUPATION ____________________________ SS# ______________________________

<> <> <> <> <> <> <>

FATHER'S NAME ______________________________

FATHER'S ADDRESS ______________________________

FATHER'S PHONE INFORMATION:

HOME ___________________WORK _____________________CELL ______________________

PLACE OF EMPLOYMENT ______________________________

ADDRESS OF EMPLOYER ______________________________

____

(rev. 2023)

The Lord is My Shepherd (Psalm 23:1)

OCCUPATION ______________________________ SS# __________________________________

PAGE TWO OF REGISTRATION FORM FOR A CHILD

PATIENT'S NAME ____

LEGAL GUARDIAN, IF NOT PARENT ____

GUARDIAN ADDRESS ____

GUARDIAN'S PHONE: HOME______________WORK_____________CELL_______________

RELATIONSHIP OF GUARDIAN TO CHILD ____

<> <> <> <> <> <> <>

NAME OF RESPONSIBLE PARTY____

RELATIONSHIP OF RESPONSIBLE PARTY TO CHILD ________________________________

ADDRESS OF RESPONSIBLE PARTY ____

HOME PHONE _____________WORK PHONE______________CELL PHONE _____________

RESPONSIBLE PARTY'S EMPLOYER ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY____

POLICY #____GROUP #________________________

PHONE # OF INSURANCE COMPANY____

ADDRESS OF INSURANCE COMPANY____

____

NAME OF INSURED____

INSURED SS#_____________________________INSURED BIRTHDATE___________________

RELATIONSHIP OF INSURED TO PATIENT ____

<> <> <> <> <> <> <>

SECONDARY INSURANCE COMPANY____

POLICY #__________________________________GROUP #_______________________________

PHONE # OF INSURANCE COMPANY ____

ADDRESS OF INSURANCE COMPANY ____

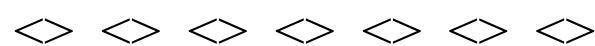
____

NAME OF INSURED____

INSURED SS#__________________________ INSURED BIRTHDATE ____________________

RELATIONSHIP OF INSURED TO PATIENT ____

PATIENT'S NAME____



EMERGENCY NOTIFICATION

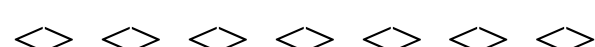
NAME OF CONTACT PERSON____

ADDRESS OF CONTACT PERSON____

____

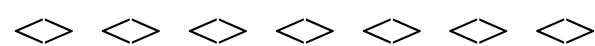
HOME PHONE______________WORK PHONE______________CELL PHONE_____________

RELATIONSHIP OF CONTACT PERSON TO CHILD____________________________________



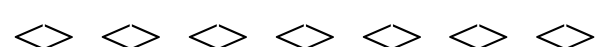
CHILD'S IMMEDIATE FAMILY (INCLUDE ALL PERSONS OTHER THAN PARENTS WHO LIVE WITH THE CHILD)

NAME	RELATIONSHIP	AGE
____________________________	____________________________	_____________
____________________________	____________________________	_____________
____________________________	____________________________	_____________
____________________________	____________________________	_____________



CHILD'S SCHOOL ____

CHILD'S GRADE: _______ CLASSES: REGULAR____RESOURCE_____SPEC. ED_____

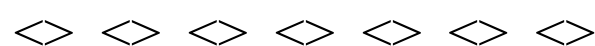


DOES THIS CHILD HAVE ANY MEDICAL PROBLEMS? ______________________________

IF YES, PLEASE EXPLAIN____

____

____



DOES THIS CHILD TAKE ANY MEDICATION____________IF YES, PLEASE LIST:

NAME OF MEDICATION	DOSAGE	FREQUENCY
_________________________	____________________	____________________
_________________________	____________________	____________________
_________________________	____________________	____________________

PATIENT'S NAME: ____

Does this child have a history of previous mental health services? Yes _________ No __________

If yes, please list below

Type of Service	Dates	Provider

<> <> <> <> <> <> <>

Does this child use alcohol or other drugs? _________YES ________NO

If yes, what does he/she use? ______________________________________

How frequently? ______________________________________

How much? ______________________________________

<> <> <> <> <> <> <>

DOES THIS CHILD HAVE ANY LEGAL HISTORY? ___________YES __________NO

If yes, please explain: ______________________________________

____

RELIGIOUS AFFILIATION______________________________________

PLEASE LIST THE CHILD'S LEISURE INTERESTS______________________

____

____

<> <> <> <> <> <> <>

BRIEFLY DESCRIBE THE PROBLEM(S) OR ISSUES FOR WHICH YOU BROUGHT THIS CHILD HERE: ______________________________________

____

____

____

____

____

____

PATIENT'S NAME: ____

BRIEFLY DESCRIBE YOUR GOALS FOR THIS CHILD'S THERAPY______________________

____

____

____

____

____

____

____

____

IS THIS CHILD INVOLVED IN ANY SORT OF LITIGATION? ________ YES ________ NO

If yes, please explain: ____

____

____

PLEASE SHOW YOUR INSURANCE CARD TO THE RECEPTIONIST SO THAT WE CAN MAKE A COPY OF THE CARD.

Floyd Covey, D.D.; Th. D.; Ph. D.; C. Carm. of C.T.P.; O.SS.T.
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AUTHORIZATION TO PROVIDE PSYCHOLOGICAL CARE TO MINORS

I certify that I, ___________________________________ am the custodial parent or legal custodial guardian of ______________________________, who is a minor or dependent under the laws of the State of Tennessee.

I, _________________________________, request and authorize Dr. Floyd Covey to provide psychological care to ___________________________. Such care may include, but is not limited to, personal interviews, therapy sessions, psychological tests, and other generally accepted practices in the field of psychology.

Name of Patient: ____

Signature of Patient: ____ Date: _________

Name of Guardian (If Patient is a Minor): ______________________________________

Relationship of Guardian to Patient: ____

Signature of Guardian: ______________________________________ Date: _________

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TELEPHONE CONTACT PERMISSION FORM

In the event that our office needs to contact you by telephone for any reason, please indicate your preferences. Please rank from 1-3 the order in which you prefer we use

_____**HOME PHONE #**

____
Area Code – Phone number

_____ Only to you
_____ Voice Mail/Answering Machine
_____ Anyone who answers
_____ Specific Persons – LIST
____
____
____

____**CELL PHONE #**

____
Area Code – Phone number

_____ Only to you
_____ Voice Mail/Answering Machine
_____ Anyone who answers
_____ Specific Persons – LIST
_____ Can we text you at this number
____
____

_____**WORK PHONE #**

____
Area Code – Phone number

_____ Only to you
_____ Voice Mail/Answering Machine
_____ Anyone who answers
_____ Specific Persons – LIST
____
____
____

List your email address if we may contact you via email for appointment reminders.

________________________________@ _____________________________

Name of Patient: ____
Signature of Patient _____________________________ Date: ___________
Name of Guardian, (If Patient is a Minor): ____________________________
Relationship of Guardian to Patient: _________________________________
Signature of Guardian: _________________________ Date: _____________

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SIGNATURE ON FILE CARD

________ I authorize Dr. Covey and his staff to use this form on all of my insurance submissions.

________ I authorize Dr. Covey and his staff to release information to all of my insurance companies.

________ I understand that I am responsible for my bill with Dr. Covey.

________ I authorize Dr. Covey and his staff to act as my agent in helping me to obtain payment from my insurance company/companies.

________ I authorize the insurance company to make payment directly to Dr. Floyd Covey.

________ I permit a copy of this authorization to be used in place of the original.

AUTHORIZATION TO RELEASE INFORMATION CONCERNING MY APPOINTMENTS

I authorize Dr. Covey and his staff to release information concerning my appointment times, locations, and dates (NOT counseling discussions) to the following people and/or insurance company.

1. ____
2. ____

AUTHORIZATION TO RELEASE INSURANCE AND BILLING INFORMATION

I authorize Dr. Covey and his staff to release information concerning my insurance and billing account with Dr. Covey to the following people (such as spouse or accountant):

1. ____
2. ____

Name of Patient: ____
Signature of Patient: ________________________________ Date: ____________
Name of Guardian (If Patient is a Minor): ________________________________
Relationship of Guardian to Patient: ________________________________
Signature of Guardian: ________________________________ Date: ____________

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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) I have certain rights to privacy regarding my PROTECTED HEALTH INFORMATION (PHI). Further, I understand that my protected health information can, and will be, used routinely in the following ways:

- To conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, either directly or indirectly.
- To obtain payment from third party payers.
- To conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received and read your PATIENT NOTIFICATION OF PRIVACY RIGHTS DOCUMENTS, which contains a more complete description of the uses and disclosures of my Protected Health Information. I understand that you have the right to change your PRIVACY RIGHTS DOCUMENT from time to time and that I may request a copy of the revised DOCUMENT.

I understand that I may request in writing that you restrict how my protected mental health information is either used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions. If you do agree in writing, then you are bound to abide by my restrictions.

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of PROTECTED HEALTH INFORMATION (PHI). Commonly referred to as the “medical records privacy laws,” HIPAA provides patient protection related to electronic transmission of data (“the transaction rules”), the keeping and use of patient records (“privacy rules”), and the storage access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care providers. Providers and health care agencies throughout the country are now required to provide patients with a notification of their privacy rights as it relates to their health care records. You may have already received notices similar to this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. My PATIENT NOTIFICATION OF PRIVACY RIGHTS is my attempt to inform you of your rights in a simple fashion. Please read this document, as it is important that you know what patient protections HIPAA affords to all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship. Accordingly, you will find that I will do all that I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for clarification.

By law, I am required to secure your signature below, indicating that you have received this PATIENT NOTIFICATION OF PRIVACY RIGHTS. Thank you for your thoughtful consideration of these matters.

Name of Patient: ____
Signature of Patient: ________________________________ Date: ____________
Name of Guardian (If Patient is a Minor):______________________________
Relationship of Guardian to Patient: ___________________________________
Signature of Guardian: _____________________________ Date: ___________

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PRACTICE POLICIES

Welcome to my office!! Communication is the cornerstone of an effective relationship. The following information is provided to patients to assist them in understanding the policies and procedures at my office. Please talk with my staff or me at (901) 854-9030 to discuss any questions which you may have regarding our services. We will make every effort to develop a professional relationship that is satisfactory to both you and us.

Attached to this PRACTICE POLICIES FORM is the NOTIFICATION OF PATIENT RIGHTS DOCUMENT, which is required with the passage of the federal "medical records privacy law," which is known as HIPAA (Health Insurance Portability and Accountability Act). I am required by law to give you a copy of this Document and to secure your signature indicating that you have received a copy of it. In my NOTIFICATION OF PATIENT RIGHTS, I have attempted to inform you of your rights in simple language.

FEE POLICY

The fee for the initial evaluation is $250.00. Fees for outpatient services are based on a rate of $175.00 per 38-52-minute session. Individual and couples psychotherapy is $175.00 per 38-52-minute session and $100.00 per 16 to 37 minute session. Telephone consultations and other services are charged according to the standard hourly rate ($175.00). Inpatient visits in the hospital are billed at $250.00 per hour and $125.00 per 30-minute consultation, with a minimum of $100.00 per visit. Forensic services and corporate consultations are billed at the rate of $350.00 per hour. Letters written on your behalf are billed at $27.00 per page. Requested copies will be billed at a $1.00 per page. Written psychological reports are billed at $45.00 per page

TESTING POLICY

Patients are frequently evaluated by using the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). This psychological test requires about ninety (90) minutes to complete and costs $129.00. Charges for psychological tests, for special psychological evaluations, and for report preparation are billed separately at a charge of $45.00 per page and are in addition to the therapy fee charges. The fee for Psychological Testing Reports is $150.00.

APPOINTMENT POLICY

Appointment times are individually reserved for patients. Cancellations must be made twenty-four hours in advance. Otherwise, you will be billed for the visit. Missed appointments cannot be billed with the insurance company and/or health care plan. Thus, charges for missed appointments are the sole responsibility of the patient and/or guardian. Questions regarding appointments, charges, and insurance matters are handled by my staff at (901) 854-9030.

PAYMENT FOR SERVICES

Fees are payable at the time of each visit. Prompt payment simplifies procedures and minimizes costs. **A $5.00 Billing Fee will be added to each bill which is sent to the patient.** If prompt payment is not possible, I will discuss a monthly payment program for you. Such special arrangements must be made with my Billing Department and will involve a written contract which specifies the terms of the agreement.

INSURANCE MATTERS

Your health insurance plan may provide reimbursement for psychological services. You should consult your policy for specifics. As a service, we will file a claim with your insurance carrier. This will enable you to receive reimbursement for your payment. At times, we may be able to accept assignment of your insurance benefits. Should this be the case, we ask that you make your co-payments at the time of service. However, since we are not a party to the agreement with your insurance carrier, the entire bill always remains your responsibility. Delinquent accounts may be submitted to a professional agency/attorney for collection. If your account is placed with a collection agency or attorney, all costs (including court costs and attorneys' fees) will be your responsibility. Many insurance companies and/or health care plans require an initial pre-certification

of care before you can use your insurance benefits. It is YOUR responsibility to make certain that such pre-certification requirements are met by you, if you elect to use your insurance benefits.

In filing your insurance claim for you, it is understood that you are granting me permission to reveal confidential information to the insurance company and/or health care plan. I may be required to submit an extensive report to the insurance company, in order to document the clinical necessity for your care. It may be necessary to reveal the details of your care. The compromising of your confidentiality is standard in today's marketplace whenever one elects to use insurance coverage for services rendered.

CONFIDENTIALITY

Tennessee law states: "The confidential relations and communications between licensed psychologists … and clients are placed upon the same basis as those provided by law between attorney and client…." This means that confidential information is controlled by the client or his/her legally competent representative There are two exceptions to this rule.

First, Tennessee law requires that child abuse be reported to the Department of Human Services.

Secondly, in the case of an emergency or where there is imminent danger to the patient or other persons, the psychologist may breach the requirement of confidentiality. Additionally, when a patient is referred to or by a physician or other professional, communication regarding treatment considerations may be maintained with that professional unless the patient specifies to the contrary. Further, under the following circumstances, we may be required to breach confidentiality: 1) if you present a danger to yourself or others; 2) if treatment is ordered by or under supervision of the courts; or 3) if a legitimate court order is issued.

Additionally, insurance companies and managed health care organizations representing third-party payers often require you to consent to a release of records and/or information (including but not limited to diagnosis, type of services rendered, dates of service, treatment plan, and other related confidential information) to them as a condition for reimbursement. Your signature below indicates your permission for us to release the requested information to your insurance company or its representative. When such information is revealed to insurance companies or managed health care organizations, we cannot control how the material is treated. Information revealed in marital therapy is also protected privileged communication and requires permission of both persons to waive confidentiality. If, because of nonpayment of your bill, we pursue legal remedies, many aspects of your relationship with us will not be considered confidential.

BENEFITS AND RISKS OF THERAPY

Psychotherapy and counseling are designed to help people increase their understanding and awareness of problem areas and to learn more effective methods of dealing with these issues. There are potential risks, as well as potential benefits in this process. Psychotherapy and counseling may involve the risk of remembering unpleasant events and experiencing intense emotions. People sometimes report feeling worse before feeling better. In personal relationships (e.g. marital relationships), it is possible for one party to develop or change in such a way as to grow apart from his or her partner, and thus weaken or dissolve the relationship.

The potential benefit from therapy may be the ability to handle or cope with the stress and problems in your life and to experience more satisfaction from relationships. You may also gain a better understanding of your personal goals and values, leading to greater maturity and personal growth, increased general satisfaction with life, and an improved sense of "well-being."

Psychotherapy and counseling are endeavors which require a great deal of effort. Even though I provide my time and professional knowledge and services, I cannot promise or guarantee specific results. I feel strongly about providing you with quality mental health care and services. Consequently, I will regularly review with you your goals and progress in treatment. At any time, you have the right to decide not to receive my services and to end our work together. There is not a moral or legal obligation; nor is there any financial obligation other than to pay for services already rendered. I do encourage you to discuss with me your decision to terminate your treatment plan. If you do decide to terminate our relationship, I can provide you with the names of other mental health professionals.

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PRACTICE POLICY
PATIENT AGREEMENT

I have read or have been given the opportunity to read the Practice Policies of this office. I understand the information fully with respect to the proposed treatment. I understand and accept the risks inherent in the course of psychotherapy proposed for me. I hereby give my consent and agree that Floyd Covey, Ph. D. may release such information as may be required by my insurance company or managed health care organization for payment for services rendered to me. I agree to hold Floyd Covey, Ph. D. harmless for any injury or claim for damages arising from release of my records or information as required by my insurance company or managed health care organization.

Do you have any questions about fees, confidentiality or other matters? ________ Yes _______ No

If Yes, please specify: ____

____

Do you agree with the conditions and provisions of these Practice Policies? ________ Yes _______ No

If No, please specify: ____

____

Name of Patient: ____

Signature of Patient: ____ Date:__________

Name of Guardian (if patient is a minor: ____

Relationship of Guardian to Patient: ____

Signature of Guardian: _________________________________ Date: ________________

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FINANCIAL AGREEMENT

All services rendered in our office are the financial responsibility of the patient and/or guardian, not the insurance company. Patients or guardians are requested to pay the charges at the time of treatment, unless prior arrangements have been made in writing.

As a courtesy, Dr. Covey will file claims with the insurance company and/or health care plan for the services which are provided to the patient. However, this does not release the patient and/or guardian of the responsibility to pay the charges for services rendered.

If the insurance company and/or health care plan deny payment or in any other way do not cover the charges for services rendered, the charges are still the responsibility of the patient and or guardian.

I understand that securing benefits under my insurance company or health care plan will require that Dr. Covey provide my confidential information to the insurance company or health care plan. Sometimes, the company or plan may require the release of extensive information in order to consider payment of the claim.

I, ____, agree to assume responsibility for 30% Collection fees and 30% Attorney fees, which may be incurred in collecting payments on this account. If collection procedures become necessary to recover fees owed on this account, I hereby give permission to Floyd Covey, Th.D., Ph.D. and his administrative staff to release any of my protected health information which may be appropriate to the collection of fees owed to Floyd Covey, Th. D., Ph. D. and/or his collection attorney and/or agency.

CHARGES FOR CORRESPONDENCE, BILLING FEES, NS/LC AND COPIES

Letters to other professionals (physicians, psychiatrists, attorneys, etc.):	$ 27.00 per page
Copies:	$ 1.00 per page
Psychological Reports:	$ 45.00 per page
Report on Bariatric, Pain, etc.	$ 150.00
Reports to Insurance Companies starting at	$ 35.00 depending on length
Billing Fees:	$ 10.00 per bill sent.
No Show/Late Cancellation of Appointment:	$ 75.00

Name of Patient: ____
Signature of Patient: ______________________________ Date: ______________
Name of Guardian (If Patient is a Minor): ______________________________
Relationship of Guardian to Patient: __________________________________
Signature of Guardian: ____________________________ Date: ______________

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NO SHOW/LATE CANCELLATION OF APPOINTMENT -- I understand that Dr. Covey's office will attempt to send me a **CONFIRMATION TEXT, AND/OR CALL ME AT THE PHONE NUMBER I HAVE PROVIDED TO "CONFIRM" APPOINTMENT** 48 hours prior to scheduled appointment. Failure to confirm within **24 HOURS OF APPOINTMENT TIME** WILL RESULT IN CANCELLATION OF MY APPOINTMENT.

If I cancel my appointment with LESS THAN 24 hours' notice, or if I do not show to my appointment, I understand that I WILL BE BILLED $75.00 for the missed appointment plus a Billing Fee of $10.00 for each bill sent.

Patient's Initial's ________

In agreeing with these terms, you are authorizing us to bill you for ANY NO SHOW OR LATE CANCELLATION OF SCHEDULED APPOINTMENTS.

CANCELLATIONS -- Appointments that are cancelled **WITHIN 24 hours' notice WILL NOT BE BILLED.**

Patient's Initial's ________

The reason for this procedure is straightforward. If a patient does not keep an appointment, Dr. Covey has **NO SOURCE OF INCOME** for the period of that appointment.

INSURANCE COMPANIES DO NOT PAY FOR MISSED APPOINTMENTS.

WORK RELATED EXCUSES

- Dr. Covey does not authorize patient absences from work.
- He does not authorize patients to return to work. If you need such an authorization, please contact your physician.
- Dr. Covey can furnish you with a form indicating that you had an appointment in his office.

Patient's Initial's ________
****

Name of Patient: ____

Signature of Patient: ____ **Date:** ______________

Name of Guardian (if Patient is a Minor): ____

Relationship of Guardian to Patient: ____

Signature of Guardian: ______________________________________ **Date:** ______________

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DR. COVEY IS NOT A FORENSIC PSYCHOLOGIST

What does this mean?

He does not become involved in ANY sort of legal action or proceedings.

He does not become involved in any child custody cases; Court-ordered testing; Child Protection Services cases; divorce cases; or any type of case involving appearances in court, responding to requests from attorneys, or to subpoenas.

If you are involved in any sort of legal proceeding or anticipate being involved in legal proceedings, Dr. Covey may not accept you as a patient.

Are you involved in any sort of legal proceeding, or do you anticipate being involved in any sort of legal proceeding?

_______ YES _______ NO

My signature below indicates that I have read and understand these statements.

______________________________ SIGNATURE ________________ DATE

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