1103 E. Main St.
Brownsburg, IN 46112
Phone: (317) 852-6603
Fax: (317) 250-2939

Date: _____
Therapist: _____

Patient Information

Name: _____ Date of Birth: _____ Age: _____
Address: _____ Social Security #: _____ Sex: _____
_____ Marital Status: _____ Date: _____
City: _____ Spouse Name: _____
State: _____ Zip: _____ Divorce Date: _____
Primary Phone: _____ { } Home { } Cell { } Work
Alternate Phone: _____ { } Home { } Cell { } Work
Permission to leave a message: { } Yes { } No
Email: _____ Permission to contact via email: { } Yes { } No

Patient Employment/School Information

{ } Employed { } Retired { } Unemployed { } Student { } Other: _____
Employer: _____ Phone: _____
Length of time at current employer: _____ Permission to contact you at work: { } Yes { } No
Highest Level Education Completed: _____
School: _____ Grade: _____ Special Ed: { } Yes { } No
Contact Person: _____ Phone: _____

Guarantor

{ } Same as Patient
Name: _____ Employer: _____
Address: _____ Phone: _____
_____ Social Security #: _____
City: _____ Date of Birth: _____
State: _____ Zip: _____

Primary Insurance

{ } Same as Patient { } Same as Guarantor { } Other: _____
Insured Party: _____ Insurance Company: _____
Relationship to Patient: _____ ID #: _____
Insured SS#: _____ Group #: _____
Insured DOB: _____ Insured Phone: _____

Income Information

Total Household Annual Income: _____
Living in the home: Number of Adults: _____ Number of Children: _____

Family Information

Spouse's Employer _____ Job Title: _____
Age: _____ DOB: _____ Highest Level Education Completed: _____

Your Parent's Names & Ages: _____
Children(s) Names & Ages: _____
Sibling(s) Names & Ages: _____

Medical History

Family Physician: _____ Phone: _____
Current Medical Condition(s):_____
Chronic Medical Condition(s):_____
Current Medication(s), Dose(s), Prescriber(s):_____
_____
Previous Counseling/Psychotherapy: { } Yes { } No
If yes, list location(s) and date(s):
_____
_____
_____

Referral Information

How did you first learn of Brownsburg Guidance & Counseling Center?
Check all that may have led to you scheduling your initial appointment:

{ } Internet { } Yellow Pages { } Friend/Relative { } Physician { } Current or Former Client
{ } Other: _____

Reason for seeking treatment: _____
_____
_____
_____
_____

HIPAA / HITECH Acknowledgement

My signature below indicates I have read and understand all of the information presented in this form. My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and The Health Information Technology for Economic & Clinical
Health Act (HITECH). I understand this information will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly or indirectly.
- Obtain third party payment for my mental health care services, as applicable.
- Conduct mental health care operations such as quality assessment and improvement activities.

I have been informed of Brownsburg Guidance & Counseling Center's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected mental health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my mental health provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out

treatment, payment, or mental health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Consent to Treat, Guarantor's Statement, & Authorization to Release Information

Permission is hereby granted to Brownsburg Guidance & Counseling Center to administer assessment(s) and treatment(s) as deemed necessary for myself and/or the patient named on this registration. I have received notification of the rights of the confidentiality of patient records. I acknowledge I have received notice of privacy practices. I hereby request and authorize Brownsburg Guidance & Counseling Center to release all or any part of my medical records to any insurance company(s) which is or may be liable for all or part of my charges. I acknowledge that I have been advised of the policies and procedures regarding treatment and fees involved. I hereby authorize and assign all payments made directly to Brownsburg Guidance & Counseling Center for all insurance benefits otherwise payable to me. I agree to pay all accumulated charges not covered by verified and assigned insurance.

Signature: _____ Name: _____

Relationship to Patient: _____ Date: _____

Witness: _____ Date: _____