Misty K. Hook, Ph.D. Counseling Services
101 West McDermott, Suite 119 ☺ Allen, TX 75013 ☺ 214-244-5835

CLIENT REGISTRATION

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which was provided separately, explains HIPAA and its application to your personal health information in greater detail. When you sign this document, it will also represent an agreement between us and your understanding of the limitations on confidentiality.

PATIENT: ____ Today's Date:_____/______/______
First Name Middle Last Name
Social Security #: ________/________/__________ Sex: M F Date of Birth: ____/ ____/_____ Age: _______
Address: ____
Street City State Zip
Home Phone: ___________________________ Work Phone: ______________________Okay to call at work: Y N
Email Address: __________________________ Okay to use email: Y N
Employer: ___________________________________ Occupation: _____________________________________
Relationship Status: (circle) Married Partnered Single Divorced Separated Widowed
Partner's Name: ____Phone: ______________________
Education: _________________If patient is a minor child: ______________________Date of Birth: ___/____/______
Custodial Parent/Guardian

INSURANCE AND BILLING INFORMATION: Method of Payment: (circle) check cash
Primary Insurance Company: ____Group #: ____________________
Policy Holder's Name: ____ Date of Birth: ____/ ____/______
Policy Holder's ID#: _________________________________ Employer: ____________________________________
Patient's relationship to insured: (circle) Self Spouse Partner Child Other

REASON FOR APPOINTMENT: (circle all that apply) Alcohol Anger Anxiety Behavior Problem Custody Issues Depression Divorce Drugs Eating Disorder Educational/Vocational Issues Family Problems Finances Insomnia Inferiority Irrational thoughts Legal Partner Problems Mood Swings Panic Attacks Physical Abuse Physical Complaints Work Problems Self Control Shyness Sexual Abuse Stress Suicidal Thoughts Temper Other:_________________________________
Who suggested you contact this office: ____
Primary Care MD: ____ Phone: _______________
Major HealthProblems:____
Medications currently taken: ____
Have you seen a mental health professional before, if so please give name, date and reason:
____
Is this counseling related to a legal issue: Judge/Attorney ____

PATIENT RESPONSIBILITY:

1. **A payment is required after each session, unless prior arrangement is made.**
2. **Your receipt is a universal insurance form and when signed by the doctor may be submitted with your insurance form to the carrier.**
3. **Fees will be charged for each scheduled appointment unless canceled 24 hours in advance.**
4. **Dr. Misty Hook does not receive incentives for participation in any third party payment program.**

Privacy and confidentiality are of the highest importance to successful therapy! You have been provided the "Notice" and understand limits to the disclosure of your protected health information. Limits of confidentiality will be discussed with you during treatment and as needed to request restrictions and amendment.

- ☐ **I give my consent for releasing minimum necessary information to insurance carrier so they can be billed.**
- ☐ **I do not give my consent for releasing information to insurance carrier and/or PCP.**

Please sign below indicating that you understand and accept financial responsibility for treatment and understand the uses and disclosure of protected health information.

____
Signature Date