REGISTRATION FORM – Client Information

Date of 1st Appointment _____

Preferred Name: _____ **Date of Birth:** _____

Legal Name: LAST _____ FIRST _____

Gender identity: _____ Preferred Pronouns: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Insurance Provider: _____

Email address: _____

Contact **Phone:** (_____) _____-_____ Cell _____ Home _____ Other_____

Contact **Phone:** (_____) _____-_____ Cell _____ Home _____ Other _____

May we leave a message? Yes _____ No _____

May we say we are from Integrative Trauma Treatment Center? Yes _____ No _____

Would like you to receive reminders of your upcoming appointments?

_____ **Email** _____ **Text Message**

Preferred contact method: _____ **Email** _____ **Phone Call**

Can we discuss **appointments** and/or **billing** with anyone other than you?

Name: _____ Relationship: _____

Emergency Contact: Name: _____

Relationship:_____ Phone # _____

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Client Intake Agreement

Please initial next to each statement that you agree with.

- I acknowledge and fully understand the terms and conditions of the **Informed Consent for Services Rendered through ITTC.** _____

- I acknowledge and fully understand the terms and conditions of the **Safe Place Policies** _____

- I acknowledge and fully understand the terms and conditions of the **Medication Management Policies** _____

- I acknowledge and fully understand the terms and conditions of the **Electronic Communications Policies** _____

- I acknowledge and fully understand the terms and conditions of the **Cancellation and Coverage Policy** _____

- I agree to participate in **teletherapy sessions via telephone** if deemed clinically appropriate. _____

- I understand my **Rights and Responsibilities as a Client** at ITTC. _____

By signing below, you agree to participate in treatment services rendered by ITTC

_____ _____

(Client Name) (Client Signature and Date)

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Integrative
Trauma Treatment Center

Authorization To Bill Health Insurance and Assignment of Benefits (AOB)

Consent for Treatment & Use of Records

By signing this form I voluntarily consent to treatment by the practitioners and clinical staff of Integrative Trauma Treatment Center hereafter referred to as (ITTC).

I also voluntarily consent to the use and disclosure of my protected health information (PHI) for treatment, payment, operations and other purposes that are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) as well as the Family Educational Rights and Privacy Act (FERPA).

I understand that ITTC is an integrated clinic including medical and mental health services and that my record may be shared between those internal departments for treatment, billing, and accounting purposes.

Financial Responsibility

I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me. If financial resources are desired/needed, it my duty to ask ITTC about setting up a payment plan which is determined/ approved on a case by case basis.

In the event that this visit is based on a Worker's Compensation claim and my Worker's Compensation claim is not accepted, I agree to have the fees associated with services sent to my private health insurance company.

I understand that I am responsible for understanding information about my health insurance policy and providing such information to ITTC for correct billing.

I acknowledge that not all services or providers at our clinic are covered by my insurance plan for one or more reasons, including but not limited to exclusions from my insurance plan, my insurance plan's designation of ITTC as an out-of-network provider, and/or my failure to provide my insurance card OR update our clinic with any new insurance or change in insurance.

Authorization (PLEASE COMPLETE):

I authorize payment directly to ITTC for services received. I accept responsibility for all charges if I do not have medical insurance. I have been informed that the services provided may not be covered by my insurance plan. I elect to proceed with service with the understanding that I may be personally responsible to pay for the service being rendered to me.

By signing this document I am consenting to all of these terms and policies.

_____ _____

Patient Signature/Date Guardian or Representative Signature/Date

_____

Clinic staff signature/Date

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Integrative Trauma Treatment Center
811 NW 19th St Suite 102 Portland, OR 97209
p: 971-266-6910 f: 888-972-3623

ACKNOWLEDGEMENT OF THE RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's **HIPPA Notice of Privacy Practices.**

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

Parent ___ Guardian ___ Power of Attorney ___ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

_____

Office use only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **HIPPA Notice of Privacy Practices.** It could not be obtained because:

____ An emergency prevented us from obtaining acknowledgement

____ A communication barrier prevented us from obtaining acknowledgment

____ The individual was unwilling to sign

____ Other: _____

_____ _____
Staff Member Signature Date

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