

Name of Patient _____



Rhode Island Counseling and Hypnotherapy Center, Inc.
Hypnosis Therapy Institute

145 Waterman Ave. Providence, RI 02906
401-241-8368

20 Danforth St Rehoboth MA 02769
774-565-0027

Date: _____ SS# _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Sex: F M

Telephone numbers:

Home: _____

Work: _____

Email: _____

Pager: _____

Cell phone: _____

Person to contact in case of emergency _____

Telephone number(s) : _____

Relationship: _____

Insurance Information:

Medical Insurance: _____

Policy Number: _____

Policy Telephone #: _____

Insurance Address: _____

Name of person holding insurance _____

Relationship: _____

Date of Birth of card holder _____

If you have two insurance companies please complete the next section:

Second Insurance Name: _____

Policy Number: _____

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Date: _____

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Policy Telephone #: _____

Insurance Address: _____

Name of person holding insurance _____

Relationship: _____

Date of Birth of card holder _____

Employment Information:

Place of Business: _____

Address: _____

Current Occupation: _____

Education Information:

Education:	1,2,3,4,5,6,7,8,	_____ Elementary/Jr. High School
(circle highest grade)	9,10,11,12	_____ High School
	13,14,	_____ Associates Degree (in what _____)
	15,16,17,18,	_____ Bachelors (in what _____)
	19,20	_____ Masters Degree (in what _____)
	20+	_____ Post Grad (in what _____)
		Certificate Program (in what/ _____)

Family Information:

Marital Status: _____

Name of spouse/significant other: _____

Social Security number: _____

Date of birth Spouse/Significant other _____

Age of Spouse/Significant other _____

Years Married/living together: _____

Children # of: _____

Names and ages of children:

Other Household Members: Names, ages, relationships

_____:

Religious Background: _____

Name of Patient _____

From whom did you hear about Rhode Island Counseling and Hypnotherapy Center?

Chief Complaint:

Briefly describe the problem(s) for which you are seeking treatment, including the severity and how long you have had this (these) problem(s). _____

Therapy History:

Whom have you consulted for this problem: (e.g. MD, Friend, etc)

Provide name and relationship: _____

Give a brief description of how you think RICHC can help you and what type of treatment you are expecting (e.g. individual psychotherapy, clinical hypnosis, biofeedback, art therapy)

Have you ever been in therapy before? Yes _____ No _____

Name of person _____

Address _____

Telephone Number _____

How long were you with this person? _____

What diagnosis were you given? _____

HIPPA Compliance: I give RICHC, Inc. permission to contact all providers necessary to provide continuity of care.

Consent to outreach for prior treatment information? Yes _____ No _____

Medical Professional taking care of you:

Name of current medical doctor PCP? _____

Address: _____

Telephone number: _____

Name, address, and telephone number of any other providers you are seeking for treatment and for what?

Are you currently taking any medication (Rx or OTC)? Please list name, dosage and frequency?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

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What medications have you taken in the last two years and are no longer taking?

1. _____

2. _____

3. _____

Have you ever stopped taking a medication that was prescribed to you without your doctor knowing?

If yes what was that medication: _____

List allergies to medications/ food/, etc. that you have: _____

Agreement of Consent for Treatment

Signature on file

_____ Date _____

Patient's name or responsible person

Agreement of Consent for Hypnotherapy Treatment

Signature on file

_____ Date _____

Patient's name or responsible person

Agreement of Consent to contact other necessary providers who have or are currently treating you

Signature on file

_____ Date _____

Patient's name or responsible person

COURT CASES

RICHC, Inc.'s philosophy is that since it is a solo practice so on a case by case basis it will only be considered. You will be responsible for ALL cost associated to your case.

_____ Date _____

Patient's name or responsible person

NOTE TAKING

RICHC, Inc.'s philosophy due to confidentiality issues will write what is necessary to provide

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care. Should you need a written summary of any kind this will only be permissible upon your written consent with at least a two-week advanced notification. RICHC, Inc. reserves the right to what is felt necessary to provide care and information to other providers.

Signature on file

Patient's name or responsible person

Date _____

MISSED APPOINTMENTS/BILLED SERVICES

Unless cancelled at least 24 hours in advance RICHC, Inc.'s policy is to charge for missed appointments at the rate of a standard office visit. Keeping your appointment is considered part of your treatment plan. If using insurance, they will not pay this fee and you are responsible for the payment of the missed appointment. RICHC, Inc. understands that unforeseen circumstances may arise. Billed services: I understand that I will be billed for a missed appointment and for other outstanding balances, and if payment is not received within one month's time; late charges will be added to my account. If I still fail to make restitution to RICHC, Inc. after three attempts, I understand that my account will be sent to Rossi's Law Office. I also understand that if my insurance company fails to pay for whatever reason I am responsible for the total billed.

Signature on file

Patient's name or responsible person

Date _____

EMERGENCY SITUATIONS

The office is reachable by telephone at all times, 24 hours a day, seven days a week. You can leave a message on the voice mail anytime and expect a return call within 24 hours. In cases of an emergency, simply state that it is an emergency in the message and a return call will be made as soon as possible. However, IF YOU CAN NOT WAIT please seek attention by calling 911, your PCP, or by going to your nearest emergency treatment facility. Should RICHC, Inc. be closed (ex. Vacation) a covering mental health professional will be available to assist your needs.

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LEGAL SITUATIONS

I understand that my records are protected under the state law governing health care information that relates to mental health services and they cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations.

I understand that by choosing to use my health insurance I am authorizing the provider to supply information to the insurance company or its representative for the purposes of managing care. The information will be in the form of treatment plans or whatever documentation is in compliance with their guidelines. I also understand that I may revoke this consent at any time except to the extent that action has been taken place in reliance to it.

I understand that you are legally responsible to report any findings of child or elderly abuse, homicidal or suicidal actions caused by the patient to the appropriate authorities.

Signature on file

Patient's name or responsible person Date _____

Workman's Compensation Cases I understand that all workmen's compensation cases are billable at the regular rate of the appropriate service charge. I understand that I am financial responsible for any discrepancies in payment.

Signature on file

Patient's name or responsible person Date _____

Treatment Goals: List what you want out of treatment from RICHC, Inc.

Goal one: _____

Goal two: _____

Goal three: _____

Hobbies: List three hobbies you enjoy.

Hobby one: _____

Hobby two: _____

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Hobby three: _____

Strengths and Weakness: List three strengths you feel you possess as well as three weakness.

Strength one: _____

Strength two: _____

Strength three: _____

Weakness one: _____

Weakness two: _____

Weakness three: _____

Opportunity to provide any other information you want RICHC, Inc. to know:
