Vance Mental Health Services
601 Post Office Rd. Suite 2D
Waldorf, MD 20602
Email: THERAPY@VANCEMENTALHEALTH.NET
[O: 301-848-0461]
[F: 301-885-0922]

PATIENT REGISTRATION FORM

Patient Name:		
Patient Address:		
Phone: *(H)*	*(W)*	*(Cell)*
Date of Birth:	SSN:	
Email:		

Responsible Party (If different than patient):		
Address:		
Phone: *(H)*	*(W)*	*(Cell)*

Primary Insurance Information	**Secondary Insurance Information**
Plan Name:	Plan Name:
Subscriber:	Subscriber:
Subscriber DOB:	Subscriber DOB:
Subscriber SSN:	Subscriber SSN:
Relationship to Patient:	Relationship to Patient:
Plan ID:	Plan ID:
Group #:	Group #:

Patient, Parent, or Legal Guardian Signature:	Date:
How did you hear about us?	

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CONSENT FOR TREATMENT

LIMITS OF CONFIDENTIALITY AND PRIVACY RIGHTS

By signing this form, you are giving Vance Mental Health, partners and associates, permission to evaluate your mental health needs and to provide the necessary treatment. Your treatment is strictly voluntary and you can chose to discontinue at any time. The treatment options available to you, the benefits and side effects of those treatments, and the credentials of the person providing the treatment, are all available to you. You have the right to participate in the development of the plan for your treatment, including the goals to be achieved and the plan for discharge.

Your treatment is confidential, following all State and Federal laws to protect your privacy and the privacy of your record. Information about you cannot be released except under one of the following conditions:

- You have signed a "release of information" form that allows us to send information to a specific person or agency for a specific purpose.
- You reveal information about child abuse or neglect. We are bound by law to report suspicions of child abuse or neglect to the Department of Social Services, including abuse that occurred to a child who is now an adult. You may be invited to participate in the reporting process should it be necessary.
- There is a clear emergency, in which case we can give the pertinent information necessary to assist in the emergency (e.g., you become very ill and we need to call emergency services on your behalf).
- You indicate to us that you are in danger of hurting yourself or another person. We are then obligated to take the steps necessary to prevent the harm.

I have read this fact sheet, or it has been explained to me.

Patient, Parent, or Legal Guardian Signature:	Date:

Emergency Contact (for children, please list primary parent or guardian):

Name:	Relationship:
Phone: *(H)* *(W)* *(Cell)*	

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FINANCIAL POLICY AND AUTHORIZATION FOR BILLING

I authorize Vance Mental Health to verify and submit insurance claims on my behalf for the services rendered to me or the party I represent. I request payment be made directly to Vance Mental Health. I certify that I have provided current and accurate information regarding insurance carrier and plan, and my signature below allows for the release of clinical information to my health insurance carrier when requested by the insurance plan.

I understand that an insurance claim will be sent on my behalf, but that I retain responsibility for the financial obligation to Vance Mental Health.

I understand that there will be additional charges not covered by insurance plans for such activities as writing letters, filling out disability forms, making court appearances, giving depositions, meetings with attorneys, school personnel or other providers. These charges vary depending on the setting and the time involved. I understand the charges will be fully explained to me before they are incurred.

I understand I am expected to pay my copayment or deductible amount, if any, at the time of service. Balances over 90 days may be sent to collections. I understand I will be held financially responsible for the cost of such action. I understand that Vance Mental Health will work with me to establish a payment plan if needed, and I agree to work cooperatively with staff to fully meet my financial obligation.

CANCELLATION POLICY

I understand that an appointment is a time set aside specifically for me or my child/family member. No one else will be slotted into this time. Therefore, I understand that I must give at least 24 hours' notice to cancel my appointment, or I will be charged a late cancellation fee of $40. Vance Mental Health and Acupuncture Services retains the right to refuse to reschedule a client who has not paid their late cancellation fee or who has late canceled or missed their appointment more than two time.

I have read this fact sheet, or it has been explained to me.

Patient, Parent, or Legal Guardian Signature:	Date: