

Cassius & Associates



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ERIC CASSIUS MS, LPC, MHSP, CHT REGISTRATION FORM

(Please Print)

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>
E-Mail Address:	(Former name):		Birth date:	Age:	Sex:
Street address:			Social Security no.:	Home phone no.: ()	
P.O. box:	City:		State:	ZIP Code:	
Occupation:	Employer:			Employer phone no.: ()	
Chose clinic because/referred to clinic by (Please check one box):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	
Other family members seen here:					

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):		Home phone no.: ()	
Is this person a patient here?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Occupation:	Employer:	Employer address:		Employer phone no.: ()	
Is this patient covered by insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Please indicate primary insurance	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Cigna	<input type="checkbox"/> Aetna	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: \$

Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.</p> <p><i>Patient/Guardian signature:</i> _____ <i>Date:</i> _____</p>			

Referred By Individual _____ Yellow Pages _____
 other _____

POLICIES AND INFORMATION REGARDING THE THERAPY PRACTICE

*****Past Treatment/History*****

	None	Outpatient	Inpatient	Both
Psychological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Drug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have had previous treatment, please list therapist(s) and where seen:

Medications and dosage: _____

1. Types of Therapy

The type of therapy that I do is varied according to the particular needs of you, the client. Normally, at our first session we evaluate together what type of therapy is appropriate, what issues to target, and how many sessions you may need.

Please check EACH type of therapy you feel may be appropriate:

- ___ 1. Marriage or Relationship Counseling
- ___ 2. Individual Counseling
- ___ 3. Hypnotherapy for _____
- ___ 4. Release Therapy - to release blocked emotions
- ___ 5. Child sexual abuse treatment
- ___ 6. Teen Counseling
- ___ 7. Group Therapy
- ___ 8. Family Therapy
- ___ 9. Other: _____

II. Areas of Treatment

Please check the areas or symptoms for which you are seeking treatment:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Stress-Related Symptoms | <input type="checkbox"/> Compulsive Behavior |
| <input type="checkbox"/> Alcohol/Drug Addiction | <input type="checkbox"/> Depression | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Sexual Addiction | <input type="checkbox"/> Smoking | <input type="checkbox"/> Co-Dependency |
| <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Low self-esteem | |
| <input type="checkbox"/> Unhealthy Relationships | <input type="checkbox"/> Incest Recovery | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Hypnosis (specify) _____ | | |

- Job Status** No Problem Disability Leave Sick Leave Worker's Compensation
 Quit Terminated Job Abolish/Lay-off Disciplinary Action

III. For Those Who Choose Hypnotherapy/EMDR

I have investigated and used many different types of treatment in an effort to be the most effective for my clients. I find that hypnotherapy/EMDR is one of the most effective and least expensive treatments available today. It is the least expensive because it requires fewer sessions overall.

In most cases I see people for a 60-minute sessions. The first half-hour is spent talking and uncovering information. Then the next 30 minutes is spent in Hypnotherapy. I find that a great deal can be accomplished with this format. In fact most clients report to me that they have received more benefit from their first hypnotherapy session than in months of regular "talk therapy".

During Hypnotherapy sessions, I will make a "reinforcement CD" which is used to extend the benefits of your session. With hypnotherapy, *the benefits continue to increase* after you leave the office and during the weeks that follow. In the long run, you will save a lot of time and money if you choose hypnotherapy as your mode of treatment. In some cases, it may be necessary to see you once per week at the beginning of treatment. As you progress, the sessions may be decreased to be every other week due to the long-lasting effects of hypnotherapy.

If you still have questions, please feel free to discuss them with me; otherwise, please sign the following agreement.

If you pre pay your sessions any missed sessions without 24 hour cancellation will count as a session and you will be charged.

I knowingly and willingly request hypnotherapy/EMDR treatment by Cassius and Associates for myself and/or my child, _____ . I acknowledge that this is in no way replacement for any medical treatment.

(Your Signature, Date, and Names of Children if applicable)

IV. If you Choose Traditional Therapy

The sessions will usually consist of 60 minutes and will be once per week. For marriage counseling, a 60 minute session will be required with each individual being seen for 20 minutes and the together for 20 minutes. Groups will meet in the evenings at 6:00p.m. Until 7:30p.m.

V. Fees and Cancellation of appointments

- | | |
|------------------|--|
| 30 min session: | \$90.00 |
| 50 min. session: | \$160.00 (SSCALE _____ PER EC _____ Date _____) |
| Hypnotherapy | \$500 for 4 sessions pre paid |
| Group: | \$75.00 |
| Court Time: | \$200.00 per hour, plus travel time unless otherwise contracted. |
| Reports: | \$75.00 to \$150.00 depending on the length of the report. |

It is important for you, the client, to recognize that when you make an appointment, we are reserving that time for you. If you are late, that cuts down on your therapy time. If you miss an appointment: that is time that could have been scheduled for another client. Therefore, it is necessary for us to charge for appointments where we have not been GIVEN TWENTY-FOUR HOUR CANCELLATION NOTICE. If you do need to cancel, we appreciate AS MUCH NOTICE AS POSSIBLE, so that someone else who may be waiting for a cancellation can arrange to come in. You may call at any time to notify us of a cancellation by leaving a message on our voice mail as it will leave the time and date of your call. Should finances become a reason for discontinuing your therapy please inform your therapist. In the event that this office must seek outside help to collect on an account the client will pay for these services.

(Your Signature and Date)

VI. Insurance Payments

If your insurance pays for a Masters level therapist, we still require payment at the time of service. **We can submit the forms for you** or supply you with an itemized statement and diagnosis, which you can submit for reimbursement. It is your responsibility to submit your own insurance claim forms. **REGARDING INSURANCE, PLEASE REMEMBER THAT THE INSURANCE IS YOURS, NOT OURS, AND THE PAYMENT OF FEES REMAINS YOUR RESPONSIBILITY.**

(Your Signature and Date)

VII. Video Tapes

In some cases, you may request to videotape your sessions.

I give my permission for my sessions to be videotaped and recognize these tapes as the property of Eric Cassius.

(Your Signature and Date)

VII. Spirituality and Religion

I respect your religious and spiritual beliefs and differences. I feel very comfortable if you choose to include these in your therapy session. I also respect your right not to include this aspect of your life in your session. Please feel free to discuss this subject with me.

IX. Open Discussion

Please feel free to discuss openly with me any aspect of your therapy or to ask any questions. I look forward to being a part of your treatment process and I feel privileged that you have chosen me to do this work with.

I have read and understand these policies.

(Your Signature and Date)

PLEASE DO NOT MARK BELOW THIS LINE.

INITIAL DIAGNOSIS (DSM IV)

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Initial GAF: _____

Highest GAF past year: _____