Kathy O'Reilly M.A., LCSWA

REGISTRATION

DATE: _____

DEMOGRAPHICS: `

NAME: _____ DOB: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: HOME: _____ CELL: _____

E-MAIL ADDRESS: _____

EMPLOYER/SCHOOL NAME: _____ PHONE: _____

SOCIAL SECURITY NUMBER: _____

SEX: PLEASE SELECT

MARITAL STATUS: PLEASE SELECT

RACE: PLEASE SELECT

PRIMARY LANGUAGE: PLEASE SELECT

EMERGENCY CONTACTS:

LEGAL GUARDIAN/RELATION: _____ PHONE: _____

EMERGENCY CONTACT/RELATION: _____ PHONE: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

INSURANCE INFORMATION:

☐ NONE
☐ MEDICAID NUMBER: _____
☐ MEDICARE NUMBER: _____
☐ PRIVATE NUMBER: _____
☐ OTHER NUMBER: _____

REFERRAL SOURCE:

☐ PHYSICIAN: _____ ☐ MENTAL HEALTH AGENCY: _____
☐ FRIEND/FAMILY ☐ PASTOR ☐ BUTTERFLY HOUSE ☐ SELF/NO REFERRAL ☐ OTHER: _____

Kathy O'Reilly M.A., LCSWA

REGISTRATION CONTINUED

IS THERE ANY MEDICATIONS CURRENTLY BEING TAKEN? (If so, for how long)

PAST SURGERIES/HOSPITALIZATIONS

CRISIS SITUATIONS/STRESS WITHIN THE PAST TWO YEARS

REASONS FOR YOUR VISIT WITH US

ANY KNOWN DRUG ALLERGIES OR OTHER ALLERGIES

Kathy O'Reilly M.A., LCSWA

Client Name: _____ Client ID: _____

AUTHORIZATION/CONSENT FORM

AUTHORIZATION FOR TREATMENT: I voluntarily request and consent to routine diagnostic, preventive, and therapeutic services and procedures by Kathy O'Reilly M.A., LCSWA, healthcare providers, and its contract agencies. I authorize the performance of appropriate treatment, including diagnostic and therapeutic that may be deemed necessary or beneficial by the provider in the care of the consumer. I understand that the practice of behavioral medicine is not an exact science and acknowledgment that no guarantees have been made as to the results of treatment or care. I further understand this consent shall remain in effect until I notify Kathy O'Reilly M.A., LCSWA in writing of my desire to withdraw my consent.

AUTHORIZATION FOR EMERGENCY TREATMENT: In case of an emergency, I authorize Kathy O'Reilly M.A., LCSWA, or its contract agency staff to obtain emergency treatment from the consumer's physician or local hospital emergency room and/or the use of an ambulance. I understand that the minimum health information, written or verbal, may be released to emergency treating providers to meet the needs of the emergency.

CONSUMER RIGHTS AND RESPONSIBILITIES: I have received Kathy O'Reilly M.A., LCSWA, *Disclosure Statement* that explains the consumer rights and responsibilities that includes the consumer grievance process, I understand that I may ask for clarification if I have questions or concerns and understand the possible benefits and/or risk involved in the process. I agree to keep all information about other consumers confidential and will not disclose or discuss with any person or agency outside of Kathy O'Reilly M.A., LCSWA.

NOTICE OF PRIVACY PRACTICES: I have also received and had the opportunity to read the *Notice of Policies and Practices to Protect the Privacy of Your Health* that explain how confidential information is used and disclosed by Kathy O'Reilly M.A., LCSWA. I understand that I should ask questions or discuss any concerns at the time of my first contact with my provider or other designated staff. I understand that I may request restriction(s) on how confidential information may be used or disclosed, and that in specific situations my request for restriction(s) may not be honored because of State or Federal laws or other special situations. ***My signature indicates receipt of a copy of Notice of Policies and Practices.***

METHODS OF CONTACTING: During and after treatment, in the following way(s):

☐ Home Telephone	☐ Home answering machine	☐ Mail to Home Address
☐ Work Telephone	☐ Work answering machine	
☐ Cell phone	☐ Cell phone answering service	☐ Other telephone: _____

I understand it is my responsibility to inform Kathy O'Reilly M.A., LCSWA in writing when I desire changes in the method of contacting me.

_____ _____

(Client - Please input signature above) (Guardian/Legally Appointed Representative)

_____ _____

(Witness - Please input signature above) (Date)

Kathy O'Reilly M.A., LCSWA

AUTHORIZATION TO DISCLOSE CONFIDENTIAL RECORDS/INFORMATION

CLIENT NAME: _____
DATE OF BIRTH: _____ CLIENT SOCIAL SECURITY NUMBER: _____ - _____ - _____
RELEASE TO/EXCHANGE FROM: KATHY O'REILLY M.A., LCSWA
RELEASE TO/EXCHANGE FROM: _____ (NAME OF AGENCY/DOCTOR/PRACTITIONER)

REQUEST FOR RELEASE OF INFORMATION

I HEREBY GIVE PERMISSION FOR THE ABOVE-NAMED AGENCY/DOCTOR/PRACTITIONER TO RELEASE ALL OF MY PERTINENT PSYCHOLOGICAL, PSYCHIATRIC, MEDICAL, AND EDUCATIONAL RECORDS, WHICH MAY ALSO INCLUDE, BUT IS NOT LIMITED TO: (CLIENTS INITIALS REQUESTED)

___DETAILS_OF_DRUG/ALCOHOL_TREATMENTS
___PSYCHOLOGICAL/PSYCHIATRIC_DIAGNOSIS
___ HIV/AIDS (IN ACCORDANCE WITH DISEASE LAWS GS120A-143

AREAS OF ARTICULAR INTEREST INCLUDE:
___ PSYCHOLOGICAL TESTING RESULTS
___ PSYCHOLOGICAL/PSYCHIATRIC HISTORY AND EVALUATIONS
___ MEDICAL HISTORY AND PHYSICAL EXAMINATIONS
___ ADMISSION AND/OR DISCHARGE SUMMARIES
___ PROGRESS SERVICE NOTES
___ OTHER: _____

THE PURPOSE OF THIS DISCLOSURE IS:
___ TO PROVIDE A THOROUGH PSYCHOLOGICAL EVALUATION
___ TO PROVIDE BACKGROUND INFORMATION FOR A TREATMENT PROGRAM
___ OTHER: _____

RELEASE FROM LIABILITY

I AGREE TO HOLD KATHY O'REILLY M.A., LCSWA AND THE ABOVE NAMED AGENCY/DOCTOR/PRACTITIONER HARMLESS AND FREE FROM LEGAL LIABITY FOR THE RELEASE OF THIS INFORMATION. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY WRITTEN NOTICE. I UNDERSTAND THAT THIS CONSENT, UNLESS PREVIOUSLY REVOKED IS VALID FOR TWELVE MONTHS FROM THE DATE OF SIGNING. A PHOTOCOPY OF THIS CONSENT SHALL BE AS VALID AS THE ORIGINAL.

_____ _____
(CLIENT - Please insert signature above) **(GUARDIAN/LEGAL APPOINTED REPRESENTATIVE)**

_____ _____
(WITNESS - Please insert signature above) **(DATE)**