**Donna M. Hammontree, L.C.S.W.**

**TH \_\_\_\_\_\_\_
DX \_\_\_\_\_\_\_ \_\_\_\_\_\_\_
GAF \_\_\_\_\_\_\_ \_\_\_\_\_\_\_
INS Pre Auth \_\_\_ \_\_\_** *For Office Use Only*

**Registration Form**

**Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_ Gender: M\_\_\_\_\_F\_\_\_\_**

**Client Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer/School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Position/Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phones: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May I contact you at home? Yes\_\_\_\_\_No\_\_\_\_\_ Leave Message? Yes\_\_\_\_\_No\_\_\_\_\_**

**May I contact you at work? Yes\_\_\_\_\_No\_\_\_\_\_ Leave Message? Yes\_\_\_\_\_No\_\_\_\_\_**

**May I contact you on your cell? Yes\_\_\_\_\_No\_\_\_\_\_ Leave Message? Yes\_\_\_\_\_No\_\_\_\_\_**

**Responsible Party for Billing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M\_\_\_\_\_F\_\_\_\_\_**

**Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phones: Home\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_% to Be Billed\_\_\_\_\_\_**

 **Additional Responsible Party for Billing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender: M\_\_\_\_\_F\_\_\_\_\_**

**Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phones: Home\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_% to Be Billed\_\_\_\_\_**

 **Insurance Information**

**Employee Assistance Program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorization #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number of Authorized Sessions\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured’s DoB\_\_\_\_\_\_\_\_\_\_Insured’s SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured’s DOB\_\_\_\_\_\_\_\_\_Insured’s SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Brief Description of Reason for Seeking Help:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Administrative Information**

**Cancellation Policy:** The Provider has the right to charge for missed appointments that have not been cancelled 24 hours in advance. Appointments will be rescheduled as soon as possible.

**Payment of Fees:** The Provider’s fee is based on the length of the session. If complete insurance information is provided, the Provider will file for insurance benefits. Payment (cash, credit or debit card, or check) is due at the time of service. \_\_\_\_ *(Initials)* Sometimes insurance payments change the amount due and there may be a delay in discovering what the amount owed is due to insurance determinations.\_\_\_\_\_ *(Initials)*

If you want Provider to bill insurance, **please sign**: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to this Provider, who will accept assignment of payment. I authorize payment of medical benefits to Donna M. Hammontree, LCSW.

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_

My deductible is \_\_\_\_\_\_. I have met my deductible: Yes No. My copayment or coinsurance is \_\_\_\_\_. I understand that I am responsible for co-payments and payments denied by my insurance. \_\_\_\_\_ *(Initials)*

I agree to inform the Provider as soon as I am aware the insurance is inactive. \_\_\_\_\_ *(Initials)*

**Informed Consent & Confidentiality:** You are consenting to treatment under the guiding principles for appropriate clinical practice established by the GA Composite Board for Professional Counselors, Social Workers, and Marriage & Family Therapists as well as by the National Association of Social Workers. You have the right to ask any questions about procedures used during your therapy, and you have the right to refuse any therapeutic procedures. You may discontinue your therapy at any time. Information revealed by you during therapy will be kept strictly confidential unless you provide written permission for me to reveal information to specific people. Information may be revealed without your permission under the following circumstances: 1) imminent risk of danger to self or others, 2) evidence of physical or sexual abuse, or 3) legitimate subpoena from a court of law.

If client is a minor, full sharing of specific thoughts and feelings with the legal guardian can be counterproductive to the treatment process so that I agree to give my child or adolescent confidentiality in regards to specifics. On the other hand, I understand I will be involved with and kept aware of the assessment and treatment plan, be informed of any of the aforementioned safety issues, and will be involved in family work as desired and needed.

I have been given an opportunity to read and keep a copy of Donna M. Hammontree’s Notice of Privacy Practices. I can contact Donna M. Hammontree, LCSW, via 7002 Hodgson Memorial Drive, Ste. 103, Savannah, GA 31406, 912-655-6521, or dhammontree@comcast.net. I understand and accept the conditions of treatment discussed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness’ Printed Name Signature Date