

# PATIENT REGISTRATION

(Please Print)

Patient's Full Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Please check one:  Male  Female

Please check one:  Married  Single  Divorced  Separated  Widowed

May we leave a message for you at the telephone numbers below? Yes No

(Patient) Home Phone: (\_\_\_\_\_) \_\_\_\_\_

(Patient) Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

(Parent, if patient is a minor) Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

(Patient) Work Phone: (\_\_\_\_\_) \_\_\_\_\_

(Parent, if patient is a minor) Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Does this patient have health insurance?  Yes  No If yes, with what company? \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

If Student, Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_

If Minor, Name of Parent/Legal Guardian: \_\_\_\_\_

*\*If Parent/Legal Guardian is divorced and seeking treatment for a minor, please provide a copy of legal custody arrangements.*

Parent/Legal Guardian's Employer: \_\_\_\_\_

Family Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient/Client Signature: \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

## CONSUMER RIGHTS

1. You have the right to care and treatment that respects your personal dignity and privacy regardless of race, religion, sex, ethnicity, age or handicap.
2. You have the right to be informed of the cost of services rendered to you.
3. All services offered through Matthews and Associates are available to you regardless of your source(s) or support.
4. Your record and counseling plan is confidential and cannot be released to anyone without you or your guardian's written consent unless there is a court ordered subpoena.
5. You have the right to an individual treatment plan and to participate in the formation of that plan.
6. Upon written request, you have the right to review your current clinical records, under the supervision of your therapist.
7. You have the right to treatment in an environment that is the least restrictive.
8. You have the right to refuse treatment or any specific treatment procedure and a right to be informed of the consequences resulting from a refusal of treatment or of a treatment procedure.
9. You have the right to request and/or be informed of alternative treatments available.
10. If you have any concerns or complaints regarding your treatment you have the right to communicate your concerns directly to your therapist and/or that therapist's immediate supervisor.
11. Coverage is available 24 hours a day, 7 days a week. In the event of an emergency after normal business hours, please call the emergency pager at 618-333-1330.

I have been given a copy of my consumer rights.

---

Patient's Signature

Date

---

Parent/Legal Guardian's Signature

Date

---

Witness' Signature

Date

Therapist: \_\_\_\_\_

Therapist Supervisor: \_\_\_\_\_

## CONSENT FOR TREATMENT

This is to certify that I give permission to Matthews and Associates to provide psychotherapy treatment for myself and/or my child(ren).

I will be treated with respect and honesty throughout treatment. I am expected to benefit from treatment, but there are no guarantees. Outpatient psychotherapy does not have significant risks. Maximum benefits will occur with regular attendance, but I understand that I may feel temporarily worse while in treatment.

While under most circumstances all communication between the client and the therapist is confidential, Illinois state law mandates the reporting of actual or suspected child or elder abuse to the appropriate agency.

It has also upheld that if an individual intends to take harmful or dangerous actions against another, it is the therapist's duty to warn the person or the family of the person who is likely to suffer the results of harmful behavior. Similar actions are taken with clients who may have suicidal thoughts and desires.

Every reasonable effort will be made to appropriately resolve these issues or to notify the client before such a compromise of the client-therapist relationship is made.

Your therapist has staff meetings with colleagues and/or supervisors on a weekly basis. Some limited confidential information may be shared during this time. Clinical consultation is a necessary and ethical component that helps in the provision of the best treatment possible.

I have the right to terminate the therapeutic relationship at any time that I should desire without fault.

I have read this consent thoroughly and have been offered the opportunity to ask questions.

A copy of this authorization shall be considered valid.

Patient/Client Name: \_\_\_\_\_

Patient/Client Signature: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_

Parent/Legal Guardian Relationship to Client: \_\_\_\_\_

Staff/Witness Signature: \_\_\_\_\_

## RELEASE OF INFORMATION

I authorize Matthews and Associates to contact my primary care physician (name),  
\_\_\_\_\_, regarding an appointment being made for follow-up, as well as information pertaining to psychological and emotional function.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Matthews and Associates

Child and Family Therapy  
Adoption & Guardianship Preservation

## ***Statement for Adoption & Subsidized Guardianship Preservation Families***

1. SERVICES ARE AVAILABLE FOR TWO YEARS. In certain situations services can be extended for an additional three months pending approval from DCFS.
2. Services are free of charge to clients.
3. If a client is being seen in the office by a therapist, and he/she misses two appointments in a row without notice, we have the right to terminate services.
4. If a client is being seen at their home by a therapist and the therapist arrives and the client is not at home *twice in a six month period*, and no phone calls canceling the visit have been made, we reserve the right to terminate services.
5. If a client needs to cancel an appointment, we request a 24-hour notice as we have many other families that need to be seen.
6. If a client is being seen in the home, we require that a parent or guardian is also present. If the therapist arrives at the home and a parent or guardian is not present, the therapist will wait for fifteen (15) minutes. If the parent or guardian does not arrive during this time, the therapist will not conduct the home session.
7. We are more than willing to loan out our books. However, if you check out a book and it is still out after two weeks, we will notify you by phone or letter. If the book is still not returned or if we do not receive a phone call within five days, we obtain the right to charge full book price for that book.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

109 Lou Ann Drive  
Herrin, Illinois 62948  
Phone: (618) 988-1330 Fax: (618) 988-8321