

CONNERY PSYCHOLOGICAL SERVICES, INC  
648 NH Route 104  
New Hampton, NH 03256  
Phone 744-0344 Fax 744-0366  
cps@worldpath.net  
www.psychservices.org

**REGISTRATION**

(Please print all information)

DATE: \_\_\_\_\_

**DEMOGRAPHICS**

Patient's name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Patient's DOB: \_\_\_\_\_

Patient's address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

Patient's primary care physician: \_\_\_\_\_

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

**FOR PATIENTS YOUNGER THAN 18 YEARS OR THOSE UNDER A GUARDIAN'S CARE**

Patient's father: \_\_\_\_\_ Telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Father's DOB: \_\_\_\_\_

Father's address: \_\_\_\_\_

Patient's mother: \_\_\_\_\_ Telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Mother's DOB: \_\_\_\_\_

Mother's address: \_\_\_\_\_

Parents are (circle one)      Married      Separated      Divorced

If the patient does not live with either parent, name of legal guardian: \_\_\_\_\_

Address of legal guardian: \_\_\_\_\_

Legal guardian's telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**CUSTODY AND GUARDIANSHIP**

***For divorced parents or appointed guardians of patients:*** In order to ensure that all legal guardians are correctly noted in our records, we require a copy of your guardianship/custody documents which outline custody arrangements and financial responsibility for mental health services rendered to the patient.

***Please include a copy of these documents with this completed intake.***

**CLINICAL INFORMATION**

I am requesting the following services for the patient (circle all that apply):

*Psychological testing      Psycho-educational testing      Competency evaluation*

*Other (explain) \_\_\_\_\_*

**What are the patient's expectations of services? (Please be specific!)**

**Does the patient have any physical disabilities, limitations, or health problems that you are aware of?**

(Please circle)            Yes            No            Don't know

If yes, please list: \_\_\_\_\_

**If patient is taking medication, who is the doctor currently managing and prescribing medication?**

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**Please list medications, dosages, frequency of administration, and when medications were started:**

\_\_\_\_\_

**Has the patient ever received psychiatric or psychological help or counseling of any kind before?**

(Please circle)            Yes            No            Don't know

Name of treatment provider and dates of service: \_\_\_\_\_

**Has patient ever had a psychological or educational evaluation done before?**

(Please Circle)            Yes            No            Don't know

If yes, who provided the assessment and when? \_\_\_\_\_

**Please enclose a copy of all prior evaluations.**

**Circle any of the following items that may pertain to the source of the patient's distress:**

Worry/Nervousness	Disruptive Behavior	Self-Control	Suicidal Thoughts
Shyness	Suspiciousness	Poor Concentration	Unhappiness
Drug Use	Euphoria/Too Much Energy	Headaches	Work
Anger	Troublesome Thoughts	Memory	Making Decisions
Sleep	Recurrent Thoughts	Insomnia	Stress
Relaxation	Problems with Authority	Inferiority Feelings	Health Problems
Legal Matters	Food Bingeing	Nightmares	Stomach Trouble
Energy/Tiredness	Sadness/Depression	Weight Problems	Hyperactivity
Loneliness	Sexual Problems	Cruelty to Animals	Financial Problems
Education	Bingeing with Alcohol	Abuse	Appetite
Family Relations	Alcoholism	Mood Swings	Body Image
Toileting	Housing Problems	Fears	Impulsivity
Menstruation Problems	Vomiting	Physical Pain	Grief
Marriage	Guilt	Temper	

**LIST ALL MEMBERS OF HOUSEHOLD**

Name	Age	Relationship	Occupation

**PAYMENT INFORMATION**

**CPS, Inc. is not within the networks of any insurance carrier.** Most insurance companies **do not pay** for the cost of a comprehensive evaluation, and many do not cover testing for educational or developmental purposes, ADD/ADHD, or for testing that is ordered by a court. They usually refuse to pay to determine eligibility for special educational services or as a condition of attending a school, college, camp or recreational program.

Please choose one of the payment methods below. Complete *all* sections within one chosen box and be very sure to sign where required.

**SELF-PAY**

An initial \$500.00 deposit is required at the time of registration. This will be credited to the final cost of the testing. Evaluation report will be released only upon our receipt of full payment.

Who is responsible for payment?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Method of Payment:

Cash

Check

Credit Card (Circle One)      Visa                      MasterCard                      American Express

**Credit Card information:**

Credit Card number: \_\_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Card holder name (please print): \_\_\_\_\_

Card holder signature: \_\_\_\_\_

I have read all of the information above and will pay Connery Psychological Services, Inc. in full before receiving a copy of the evaluation. I understand that phone calls, personal consultations, and office visits to review the report are not included in the evaluation fee.

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Today's Date

**PAYMENT THROUGH PUBLIC OR PRIVATE SCHOOL**

Name and address of the person and the school providing payment: \_\_\_\_\_

Telephone: \_\_\_\_\_

School's Method of Payment: Check  Credit Card  Bill to parent or legal guardian

**Credit Card information:**

Credit Card number: \_\_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Card holder name (please print): \_\_\_\_\_

Card holder signature: \_\_\_\_\_

I have read all of the information above and will pay Connery Psychological Services, Inc. in full before receiving a copy of the evaluation. I understand that phone calls, personal consultations, and office visits to review the report are not included in the evaluation fee.

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Today's Date

**PAYMENT THROUGH 2110 (STATE)**

Name of person and agency is responsible: \_\_\_\_\_

Billing address: \_\_\_\_\_

Name of JPPO, social worker, or lawyer: \_\_\_\_\_

Telephone: \_\_\_\_\_

Please send a copy of the court order requiring the evaluation (if there is one) along with this completed registration.

**PAYMENT THROUGH MEDICAID**

No deposit is required from currently enrolled Medicaid patients. We will process billing through Medicaid, but please note: **Medicaid will not cover patient services with CPS, Inc. if you have any other insurance coverage. We are not providers for any insurance other than Medicaid.** If Medicaid denies this claim for any reason, the undersigned agrees to pay the full amount due. The amount due will reflect Medicaid reimbursement rates.

Medicaid ID #: \_\_\_\_\_

Name on the Medicaid card (including middle initial): \_\_\_\_\_

Is patient covered by any other insurance company? (please circle)    Yes    No

If yes, what is the name of the insurance company? \_\_\_\_\_

**Any Medicaid claim that is denied for any reason will be the responsibility of the undersigned. That person will be billed at the Medicaid rate.**

I have read the information above and agree to Connery Psychological Services, Inc. terms and conditions for payment.

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Today's Date

**ELECTRONIC COMMUNICATIONS**

We do not provide mental health advice or guidance on-line, nor do we respond to mental health issues posed to us by email. We discourage you from revealing personal matters by email due to the potential for privacy/confidentiality violations.

**EMERGENCY SERVICES**

Connery Psychological Services, Inc. does not provide emergency services. If an emergency occurs before or after the assessment, and the patient is not enrolled with an outpatient provider, call 911 or go to the nearest hospital.

**CANCELLATION POLICY**

Twenty-four (24) hours notice is required for cancellation of appointments (unless an emergency situation). Patients, or their parents or guardians, if they are minors, **are personally responsible for payment in full for broken appointments.** Broken or improperly cancelled appointments cannot be billed to Medicaid.

I agree, by signing below, to abide by the payment and cancellation policy:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***Directions from Route 93***

*Exit 23, Route 104 east toward Meredith, 2 miles on left, green building, lots of windows, on a hill. 648 Route 104.*