

**CONNERY PSYCHOLOGICAL SERVICES, INC**  
**648 NH Route 104**  
**New Hampton, NH 03256**  
**Phone 744-0344 fax 744-0366**

**REGISTRATION and INFORMATION SHEET**

(Please print all information)

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

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Patient's Address \_\_\_\_\_ Telephone # \_\_\_\_\_

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

Patient's Primary Care Physician: \_\_\_\_\_

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

**PERSONAL INFORMATION:**

Patient's Father: \_\_\_\_\_ Telephone: \_\_\_\_\_ Father's DOB: \_\_\_\_\_

Father's Address: \_\_\_\_\_

Patient's Mother: \_\_\_\_\_ Telephone: \_\_\_\_\_ Mother's DOB: \_\_\_\_\_

Mother's Address: \_\_\_\_\_

**Payment Mechanism:**

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

2110 (State)  What agency is responsible? \_\_\_\_\_

Self Pay  Who is responsible for payment? \_\_\_\_\_

Daytime phone # where we can reach you \_\_\_\_\_

School  Name \_\_\_\_\_ Address: \_\_\_\_\_

**CLINICAL INFORMATION**

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

*psychological testing*                      *psychoeducational testing*                      *other* \_\_\_\_\_

What are the patient's expectations of services? \_\_\_\_\_

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

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

If patient is taking medication(s), who is currently managing and prescribing medication(s)? (Name & Phone #):

Please list medication(s), dosages, frequency of administration, and when medication(s) were started:

Have you ever received psychiatric or psychological help or counseling of any kind before? (circle): Yes No

Name of Treatment Provider & Dates of Service \_\_\_\_\_

Please circle any of the following items that may pertain to the source of the patient's distress:

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

List the members of the patient's family and all others in the home:

Name	Age	Relationship	Occupation

**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.

**CUSTODY AND GUARDIANSHIP**

***For divorced guardians of juvenile 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 medical/dental/mental health services rendered to your child. This information is required in order for us to maintain accurate records for your child's health record at CPS, Inc. ***Please include a copy of these documents with this completed intake.***

**PAYMENT POLICY**

CPS, Inc. **is not within the networks of any insurance carrier** as 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, to determine eligibility for special educational services or as a condition of attending a school, college, camp or recreational program, or for testing that is ordered by a Court. **Therefore, we require an initial deposit of \$500.00.** This will be credited to the cost of the evaluation and **must be attached to this signed registration form.** *Please note that evaluation reports are released upon receipt of full payment.* If you wish to pay with a credit card, we accept MC, VISA, and American Express. Please complete information below if you wish to have your credit card charged for any balances due. **CPS is a Medicaid Provider** and will bill Medicaid accordingly.

Name as shown on card: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Card Number: \_\_\_\_\_

I authorize CPS, Inc. to charge the above listed credit card for any balances due for services. I understand that a receipt will be mailed to me each time the card is used.

Card Holder Signature: \_\_\_\_\_ It is required that the patient or guardian will make all financial arrangements before or, at the latest, on the day of the initial appointment.

Fees not collected within 90 days will be sent to a professional collection agency. No personally identifiable treatment information will be included to the collection company.

**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.**

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

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

last updated 5/2/07