KATHERINE KO, PH.D., A PSYCHOLOGICAL CORPORATION
4950 Barranca Pkwy, Suite 310-A, Irvine, CA 92604
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NEW CLIENT REGISTRATION FORM

CLIENT INFORMATION

Name: _____ Age: _____ Birthday: _____
Last Name First Name MI

Gender: ☐M ☐F ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Partnered ☐Minor

Ethnicity: _____

If minor, name of parent or guardian: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email: _____

☐ Permission to be contacted via texts and/or email only for administrative reasons (i.e. appointment, financial matters)

Employer/School _____ Occupation: _____

In case of emergency who should be notified? _____ Phone: _____

PRIMARY INSURANCE

Person Responsible for Account: _____ Birthday: _____
Last Name First Name MI

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone _____

Insurance Company_____ Type of Plan_____

Contract # _____ Group # _____ Subscriber #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and
Name of Insurance Company(ies)

assign directly to Dr. Katherine Ko all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Katherine Ko may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Client, Parent, Guardian or Personal Representatives Date

_____ _____
Print name of Client, Parent, Guardian or Personal Representatives Relationship to Client

Reason for coming today: _____

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job performance	1	2	3	4	5	N/A
School performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Hobbies	1	2	3	4	5	N/A
Physical health	1	2	3	4	5	N/A
Anxiety level	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating habits	1	2	3	4	5	N/A
If your eating habits are affected, describe how: _____						
Sleeping habits	1	2	3	4	5	N/A
If your sleeping habits are affected, describe how: _____						
Sexual functioning	1	2	3	4	5	N/A
Spirituality	1	2	3	4	5	N/A

Habits:	Amount Currently Using	Most ever Used/When?
Coffee (cups/day)	_____	_____
Cigarettes (packs/day)	_____	_____
Alcohol (drinks/day)	_____	_____
Others: _____	_____	_____

Psychiatric History:

Have you ever received psychiatric or psychological treatment of any kind before? ☐ Yes ☐ No

If you checked Yes to the above question, please answer the following:

When were you in treatment? _____

How old were you at the time of first treatment? _____

How many times have you been hospitalized for a psychiatric condition? _____

Did your doctor prescribe medicine at that time? ☐ Yes ☐ No ☐ Not applicable

If yes, what was prescribed? _____

Substance Use History:

Have you ever used drugs or alcohol? ☐ Yes ☐ No

If yes, please describe: Substance	Amount	Frequency	When (first use, last use)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever received substance abuse treatment of any kind before? ☐ Yes ☐ No

List any significant medical history:

_____

_____

List the medications you are currently taking:

_____

_____

CONFIDENTIALITY: I understand that all information shared between my psychologist and myself is held strictly confidential unless:

1. I authorize a release of information with my signature.
2. I present a danger to myself.
3. I present a danger to others.
4. Child/elder abuse/neglect is suspected.

In the latter two cases, the psychologist is required by law to inform potential victims and legal authorities so that protective measures can be taken.

RELEASE OF INFORMATION: In addition to releases of information permitted above, I authorize discussion of my case with the referral source and other health care providers and facilities for purpose of diagnosis and treatment. By initializing below, I authorize discussion of my case with my primary care physician. _____ (**initial only if you authorize**). (Releases of information to providers, family, etc. require separate form.)

FINANCIAL TERMS: I understand that I am 100% responsible for payment for my visits and that the payments are due at the time services are rendered. If mental health insurance coverage is used, Dr. Ko will bill my insurance carrier and assist with insurance reimbursement. However, I understand that, in all cases, the charges are my responsibility. Acceptable forms of payment include cash and personal checks. Checks returned for any reasons will result in a $25.00 charge. If I become over 90 days delinquent by not paying any balance, I understand that my account and the breakdown of charges may be sent to a collection agency.

CANCELED/MISSED APPOINTMENT POLICY: A scheduled appointment means that time is reserved only for me. I will call Dr. Ko's office at Perfect Harmony, Inc. **at least 48 hours in advance to the appointment time** in the event I need to cancel or reschedule. A message may be left at 949-973-1137 if the office is closed or if Dr. Ko is unavailable. **I understand I will be charged the full rate for my session if I late cancel/reschedule or do not show up,** unless it is due to special circumstances that is beyond my control, in which case I will contact Dr. Ko as soon as possible to inform her of the situation. Insurance companies do not provide reimbursement for cancelled sessions on your behalf. **The fees charged for no shows and late cancellations/reschedules are $150.00.**

EMERGENCY PROCEDURES: If I need to contact Dr. Ko after regular business hours, I will call 949-973-1137 and follow the voice mail instructions. I will call 911 or present myself and/or my child at the ER for life-threatening emergencies. I understand that there may be a charge for telephone consultations with Dr. Ko.

I have read and understand this statement of office and financial policy and agree to its terms. I hereby give my consent for evaluation and/or treatment of myself/my child. If I am seeking evaluation or treatment for a minor child, I further certify that I have the legal authority to do so without the consent of another parent with custodial rights, or any other person. I also acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Client/Legal Guardian Name Printed Date

_____ _____

Client/Legal Guardian Name Signature Katherine Y. Ko, Ph.D., Psychologist

ADDITIONAL INSURANCE, *if applicable*

Is client covered by additional insurance? ☐Yes ☐No
Subscriber Name: _____
Birthday: _____
Address (if different from client) _____
City _____ State _____ Zip Code _____
Phone: _____
Subscriber Employed by_____
Occupation: _____
Insurance Company_____
Type of Plan_____
Contract # _____
Group # _____
Subscriber #_____

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