

NAME OF PATIENT _____

17. NAME OF PRIMARY CARE PHYSICIAN OR NURSE PRACTITIONER:

NAME CITY STATE/
ZIP

MAY WE CONTACT YOUR PRIMARY CARE PHYSICIAN OR NURSE PRACTITIONER?

IF YES, PLEASE SIGN HERE: _____ Date _____

18. CURRENTLY ON MEDICATION? NO YES (LIST BELOW)

a. _____ DOSAGE: _____

b. _____ DOSAGE: _____

c. _____ DOSAGE: _____

19. ARE THERE ANY MEDICAL CONDITIONS (INCLUDING ALLERGIES) THAT WE NEED TO BE
AWARE OF? _____

20: DO YOU, OR HAVE YOU EVER ABUSED ALCOHOL OR DRUGS: YES NO

21. BRIEFLY DESCRIBE THE REASON YOU ARE SEEKING COUNSELING. _____

22. AT TIMES IT MAY BE NECESSARY FOR US TO CONTACT YOU TO RESCHEDULE AN
APPOINTMENT. WE DO NOT WANT TO VIOLATE YOUR CONFIDENTIALITY IF WE DO THIS. PLEASE
ANSWER THE FOLLOWING QUESTIONS:

HOME: MAY WE CALL YOU AT HOME? YES NO
MAY WE LEAVE A MESSAGE FOR YOU AT HOME? YES NO
WITH WHOM MAY WE LEAVE A MESSAGE AT YOUR HOME? _____

WORK: MAY WE CALL YOU AT WORK? YES NO
MAY WE LEAVE A MESSAGE FOR YOU AT WORK? YES NO
WITH WHOM MAY WE LEAVE A MESSAGE AT YOUR WORK? _____

KEEPING IN MIND THAT CALLS RECEIVED ON CORDLESS AND CELL PHONES MAY NOT BE
CONFIDENTIAL, MAY WE CALL YOU ON YOUR CELL PHONE? NO YES

NAME OF PATIENT: _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____

NAME OF CARDHOLDER: _____ PHONE _____

ADDRESS _____ CITY, STATE, ZIP _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD PARENT OTHER

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____

NAME OF CARDHOLDER: _____ PHONE _____

ADDRESS _____ CITY, STATE, ZIP _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD PARENT OTHER

PAYMENT/INSURANCE AGREEMENT & AUTHORIZATION TO SEND REIMBURSEMENT INFORMATION

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the therapist agrees otherwise. I understand that, unless the above named patient has coverage under a managed health plan (e.g., HMO, PPO, EAP, etc.) in which the therapist is a participating provider, I am personally responsible for the payment of all charges. I understand that, as a courtesy, the provider will file insurance claims for the services provided; however, this does not release me of my responsibility for payment of the charges for services. Payment for any charges denied or not covered by my insurance company becomes my responsibility and I agree to pay these charges. I also understand that any court order I have is an agreement between myself and the courts, NOT the provider, and I am still responsible for payment of all charges. I understand and agree that I may be charged for and required to pay for missed appointments that are not cancelled at least 24 hours in advance. I further understand that a collection agency and/or the courts may be used in the event of delinquent payment, and I realize that such action could require that the provider release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed. In addition, IF I have requested that the provider file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans in the future may require that the provider provide the plan management with confidential patient information, including diagnoses and the dates and type of services rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the provider to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

PRINTED NAME OF PATIENT OR RESPONSIBLE PART