Confidential Patient Information and Consent for Treatment

DEMOGRAPHIC INFORMATION:

Name:____ Age:__________________

Who referred you:____

Street Address:____

City:____ State:_______________________ Zip:______________________

Email:____

Home Phone:_____________________________Work:_______________________________Cell:_____________________________

Name of parent or guardian if the patient is a minor:______________________ Phone:______________________Cell:______________

May I contact you by email and phone numbers? ☐ Yes ☐ No (please list exclusions) ___________________________________

PLACE OF EMPLOYMENT OR SCHOOL: _______________________________________Phone: _________________________

FAMILY:

Marital Status:: ☐ Single Married ☐ Other:____

Spouse/Partner's Name: ____________________________ DOB/Age:__________________ Phone:_________________________

Spouses Occupation:_______________________________ Place of spouse's occupation:___________________________________

Parents (Name and ages):____

Children (Name and ages):____

PATIENT MEDICAL INFORMATION:

Name of doctor:______________________________________ Phone:_________________________ Fax:______________________

List any medical problems, injuries, or allergies:____

List all medications:____

May I contact your medical doctor to coordinate care? ☐ Yes ☐ No

Whom should I contact in case of an emergency? Name:____________________________________ Phone:______________________

LEGAL INFORMATION: Are you involved in a lawsuit or legal proceedings? ____

WHAT BRINGS YOU IN FOR THERAPY AT THIS TIME?____

____

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LIST PREVIOUS MENTAL HEALTH PROVIDERS:____

____

INSURANCE ELIGIBILITY & BENEFITS:

Name as on Health ID:________________________________ SS Number:_______________________ DOB:____________________

Plan Name:____ ID #:______________________________Group #:___________________

Subscribers Name:___________________________________ Subscribers DOB: ____________________ SS #:____________________

Authorization:_________________________ Effective Date:____________ Deductible:____________ Copay:____________________

Phone # and Address to Submit Claims:____

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I authorize this office to release necessary information, including diagnosis, progress notes, etc. to my insurance company to facilitate reimbursement. I understand that I am responsible for all charges, regardless of insurance coverage or any other third party agreements. I understand it is my responsibility to pay any deductible amount, coinsurance, copay or any other balance not paid by the insurance company. This includes Late Cancellation Fees (less than 24 hours notice) of $75.00 per occurrence. Where a minor is involved, the parents or legal guardians are the responsible financial party. This release is valid from today's date forward and a photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for all charges not paid by insurance including charges resulting from any miscommunication or failure on my part to obtain preauthorization that may be required by my insurance carrier.

Your signature below also indicates that you have read the information in the Outpatient Service Agreement and HIPPA notice and agree to abide by its terms during our professional relationship.

Signature:____Date:_________________________