PATIENT INFORMATION

Patient is scheduled to see: ______________________________

Patient's Last Name: ____________________ First Name: ________________ Middle Initial: _____

Address: ______________________________ Home Phone: ____________

City/State: ______________________________ Zip Code: ____________

Place of Employment: ______________________________ Work Phone:(___) ________

May we call you at home? Y N May we call you at work? Y N Cell Phone:(___) ________

Birthdate:_____/_____/_____ Sex: M F Race: B W Other Marital Status: S M D W

Retired? Y N Disabled? Y N Social Security Number: ____________________

Referred by: ______________________________

Person to contact in case of emergency:

Name:____________________ Phone: (____)____________ Relationship: ____________

Please complete if person responsible for bill is other than the patient.

Name: ______________________________Relationship to Patient: ____________________

Address: ____________________ City/State/Zip: ____________________

Place of Employment: ______________________________ Phone: ____________

Primary Insurance	Secondary Insurance
Carrier: ____________________	Carrier: ____________________
Managed Care Co: ____________________	Managed Care Co: ____________________
Policy Holder: ____________________	Policy Holder: ____________________
DOB: __________ Rel. to Pt.: __________	DOB: __________ Rel. to Pt.: __________
Contract/Member No: ____________________	Contract/Member No: ____________________
Policy Holder's Employer: ____________________	Policy Holder's Employer: ____________________
MH Claims Address: ____________________	MH Claims Address: ____________________
____________________	____________________
MH Benefit Phone #: ____________________	MH Benefit Phone #: ____________________
Effective Date: ____________________	Effective Date: ____________________

PRESENTING PROBLEM: ______________________________

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FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay for all charges for such treatment. I hereby authorize the release of any and all medical information necessary to process insurance claims; and I authorize payment of medical benefits to this office. I am responsible for any and all amounts which insurance does not cover, including deductible amounts, charges not covered, and copayments.

I authorize my physician/therapist to conduct mental health evaluations and treatment which may involve psychotherpy and/or pharmacological management.

SIGNATURE: ______________________________ DATE: ____________________

Patient, Parent, or Legal Guardian