
NEW CLIENT INFORMATION

DATE: _____**Client Name:** _____**Last****First****Middle****Address:** _____**Street****Apt#****City****State****Zip Code****Home Phone #:** (____) _____ - _____ **Work Phone #:** (____) _____ - _____**MAY WE CONTACT YOU AT HOME OR AT WORK TO COMFIRM APPOINTMENTS****Please Check** **Home** Yes _____ No _____ **Work** Yes _____ No _____**Date Of Birth:** ____/____/____ **Age** _____ **Sex:** (Circle One) Female Male**Martial Status:** (Circle One) Single Married Divorced Widowed Other**Spouse's Name:** _____**Client Relationship To The Responsible Party:** Self Spouse Child Other**Client's Social Security Number** _____ - _____ - _____**Referred By:** _____ **Family Physician:** _____**Medications:** _____**Previous Psychotherapy:** _____ **Therapist:** _____**Chief Complaint Or Problem:** _____**Members Of Immediate Family: (Name, Age, Relationship To Client)** _____**Client's Employer Information:**

Company: _____ City: _____

Responsible (Or Insured) Party Information

Name: _____**Last****First****Middle****Address:** _____**City:** _____ **State:** _____ **Zip Code:** _____**Home Phone #:** (____) _____ - _____ **Work Phone #:** (____) _____ - _____**Date Of Birth:** ____/____/____ **Sex:** (Circle One) Female Male**Social Security Number** _____ - _____ - _____**Responsible Party's Employer Information:**

Company: _____ City: _____

Insurance Information

Primary Insurance Company: _____**Address:** _____ **Phone:** _____**Contract (Id#) Number:** _____ **Subscriber's Name:** _____**Client Relationship To Subscriber:** (Circle One) Self Spouse Child Other**Group Name:** _____ **Group Number:** _____**Co-payment Amount:** \$ _____**Secondary Insurance Company:** _____**Address:** _____ **Phone:** _____**Contract (Id#) Number:** _____ **Subscriber's Name:** _____**Client Relationship To Subscriber:** (Circle One) Self Spouse Child Other**Group Name:** _____ **Group Number:** _____**Co-payment Amount:** \$ _____

**WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.
WE PLEDGE TO GIVE YOU OUR VERY BEST CARE.**

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 1 ½ percent per month (18% per annum) or a \$5.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorney's fee. I understand that I will be charged \$85.00 for not showing up to my appointment, to be paid in full at my next appointment. I understand that I must cancel my appointment 24 hours in advance; otherwise I will be charged \$25.00.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all co-pays, deductibles, and no show charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS:

I authorize the release of client information necessary to process any insurance claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me, or my insurance company, at any time, in writing.

I understand that I will be responsible for a co-pay of _____ per hour of service. I also understand that I will be charged \$25.00 for a no-show or late cancellation.

I have been made aware of Associated Psychotherapists' Notice of Privacy Practices, effective April 14, 2003, in accordance with the Health Insurance Portability and Accountability Act of 1996.

I am aware of these exceptions to my confidentiality as defined by law:

- Threats of bodily harm made by client to another person or property.
- Court-ordered subpoena, signed by a Judge of the Court.
- Court-ordered testing.
- Evidence to suspect child abuse, neglect, assault and/or sexual molestation.
- Evidence to suspect potential suicide risk.

I am aware that my health information may be disclosed during ordinary office and accounting procedures such as: reminder calls to my home or answering machine, and bank deposits of my personal checks should I choose to use this form of payment.

SIGNED: _____ **DATE:** _____

Client, Parent or Guardian

PRINTED NAME: _____

WITNESS: _____ **DATE:** _____