NEW PATIENT INFORMATION

1) Patient

Name:_____

Birthdate: _____ Sex: Male_____Female_____

Marital Status: Single ____ Married____Divorced____ Separated____Widowed_____

Street:_____

City_____State_____Zip_____

May I mail to you at this address? Yes_____ No_____

May I E-mail you? Yes_____No_____E-mail_____

Would you like an appt reminder by (please circle one) ---TEXT, E-MAIL, PHONE or NOT AT ALL.

Would you like a statement by (please circle one) ----- MAIL or E-MAIL.

Phone _____ (Appt reminder # if different) _____

May I contact you and leave messages at these phone numbers? Yes_____ No_____

2) Patient Contacts

Have you seen this type of therapist before? Yes_____ No_____

If yes, when and with whom? _____

How were you referred to our office?_____

Who may we thank for referring you?_____

Insurance carrier (if applicable):_____Insurance phone #: _____

Subscriber:_____DOB_____

I.D. Number:_____ Group Number:_____

Physician or Psychiatrist or Ob/Gyn: _____

3) Patient Release (**Optional**) "I authorize the release of information to my Physician, Psychiatrist or Ob/Gyn for the purpose of coordinating my health care. Yes_____ No_____

(**If using an insurance plan in which a provider is contracted**) "I authorize the release of information for claims, certification/case management, and other purposes related to the benefits of my health plan. I understand that my Health Plan is to supply me with a confidentiality of Personal and Health Information packet". I also understand that my Health Plan is reimbursing the cost of therapy based on an acceptable diagnosis sent to them by the provider.

(**If using an insurance plan in which a provider is not contracted**) A super bill will be offered at the end of each session if the client would like to get reimbursed by their Health Plan. I also understand that my Health Plan is reimbursing the cost of therapy based on an acceptable diagnosis sent to them by the provider.

Signature_____Date_____