

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 _____

Phone(HM) _____ (WK) _____

May I contact you and leave messages at these phone numbers? Yes _____ No _____

If you are seeking help for a gambling addiction please add the following information for billing purposes: State born _____ Mother's first name _____

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 _____