Adult New Patient Information

Patient Name: _____ Birth date: _____

Spouse/Partner Name: _____ Birth date:_____

Mailing Address: _____
City:_____ State:_____ Zip Code: _____
Contact Numbers: Hm: _____ cell: _____ work: _____
Preferred Contact Number: _____

Work Name/Address
(Patient): _____
Work Name/Address
(Spouse/Partner):_____

Is it okay to reach you at the numbers above? □Yes □ No
If not, where should we reach you? _____

Is it okay to leave a message at the numbers above? □Yes □No
Please leave any other information you would like us to know regarding maintaining your confidentiality:
_____
_____
_____

HIPAA Compliance

I acknowledge that I have received the HIPAA Notice Form.
***Signature*: _____ *Date*: _____**

Service Agreement

I acknowledge that I have received a Service Agreement Form, reviewed this information with my clinician, and agreed to the conditions specified.
***Signature*: _____ *Date*: _____**

Payment Agreement:

I, (please print name) _____understand that I am responsible for full payment at the time of each visit unless other arrangements have been made through my therapist. One guarantor must be designated and is responsible for all fees, regardless of insurance coverage. My insurance policy may not reimburse for some (CPT) procedures and/or diagnostic codes in which case I understand that I am responsible for the balance.

Signature: _____Date: _____