Adult Information Form

Office Use: ID verified: ____ Type:________

Information About You

v9.9.10a

Name: ____Today's Date: ___________________

Mailing Address:________________________________City, State, Zip __________________, ______, __________

Home Phone: ______________________ Cell Phone:_______________________ Date of Birth: ____/____/_________

Occupation: __________________________ Work Phone: ________________ Employer: ________________________

Sex: _____ Age:_____ Relationship Status: _____________ Partner's Name: _____________________ # of Children: ___

Who is your current physician? _____________________________________ City: ________________________________

List any major medical problems: ____

Medications and dosages: _________________ ____________________ __________________ _____________________

use back if needed, or provide a list of your own

Is it OK to call and leave messages at home? ☐ Yes ☐ No | On your cell? ☐ Yes ☐ No | At work? ☐ Yes ☐ No

If you have Caller ID, would you like us to block our name when calling your home? ☐ Yes ☐ No ☐ Does not apply

Whom can we call in case of emergency? __________________________________ Phone # (_____) ______-__________

If not yourself, provide the name of person responsible for payment on your account: (The person signing this form)

☐ Self ☐ Other: ____

Social Security Number of above-named person: __________--_________--_______________

***Why we need your Social Security Number* (SSN)**: If you are not paying cash in full, your clinician becomes a business offering you credit and carrying outstanding balances on your behalf. Having your SSN (or that of the financially responsible party) allows correct identification of the person responsible for your account. Your SSN is kept secure. Not providing this number assumes you are planning to pay cash in full at time of each service.

How do you prefer to cover your expenses? ☐ Cash ☐ Insurance ☐ Employee Assistance ☐ Medicare Other___________

If insurance, name of primary insurance carrier:____

Note: Please present your insurance card so that we may make a copy for our records.
If you have dual coverage, provide us **both** cards and clarify which is primary and which is secondary.

Name of subscriber (if not yourself): ________________________________ Subscriber's date of birth: ________________

Your relationship to the subscriber: [ ] self [ ] spouse [ ] child [ ] Other:__________________________

Subscriber's Policy or Health Record Number: ______________________________ Group Number:__________________

Co-pay amount _______ ($ or %) Subscriber's Employer:____

Who referred you to our office?____

Your clinician wants to ensure that he or she is providing the best care possible based on your particular culture and language preference. Please complete the following information: (check one)

☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ White/Caucasian ☐ More than one race Are you Hispanic or Latino? ☐ Yes ☐ No

Do you prefer to communicate in a language other than English? ☐ Yes ☐ No - If yes, which?______________________

Places For You to Sign

There are three areas where we need your signature. These include: 1) your acknowledgement of having received information about your clinician, office policies, and protecting the privacy of your healthcare record, 2) allowing your clinician to speak with your medical doctor, and 3) allowing us to bill your insurance for services.

1. ***I have been provided information regarding office policies, including fees, policies regarding missed appointments and late cancellations, the right to refuse treatment, choosing the best treatment provider, and protecting the privacy of my healthcare record.***

Signature ______________________________ Date ______________

2. I prefer to work as a team with your regular physician. In fact, some insurance companies require your primary care physician to be informed of your mental health treatment.

I give my permission for my clinician to speak with my primary care physician under the following conditions:
Check one box

I don't have a primary care physician, or this issue doesn't apply to me.

I prefer my physician **not** *be contacted about my evaluation or treatment.*

My clinician can communicate only basic information about my visits here, using his/her own discretion, including dates of visits, kind of treatment, and when treatment ended.

My clinician can communicate any and all information about my visits, as needed.

Signature ______________________________ Date ______________

3. If you plan to use insurance benefits to help cover evaluation and treatment costs, you will need to allow us to communicate with your insurer. **There is no need to sign if you are <u>not</u> using health insurance to cover costs**. Your signature below allows:

- Your clinician to release basic, confidential information about you, such as date and type of service, diagnosis, and other information required to process your claim;
- Your insurance company to pay benefits directly to your clinician to be applied to your account;
- Your clinician to bill your insurance company in the future without you having to sign for this each time.

I understand that I am responsible for any charges not covered or reimbursed by my insurer. Also, I understand that this authorization is valid until withdrawn by me in writing, and that I my revoke this release at any time except to the extent that action has already been taken in reliance on my consent.

Signature ______________________________ Date ______________