Association of Behavioral Counselors PLLC

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PATIENT INFORMATION

Today's Date: _____

Last Name: _____

First Name: _____ Middle: _____

Address: _____

City: _____

State: _____ Zip: _____

SS # _____

Male ☐ Female ☐ Date of Birth: _____

Marital Status: _____

Employer: _____

Employer's Address: _____

Employer's Phone: _____

If minor, Name of School: _____

PREFERRED METHOD OF CONTACT (check appropriate box)

☐ Home Phone: _____

☐ Cell Phone: _____

☐ Work Phone: _____

☐ E mail: _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship: _____

Phone: _____

INSURANCE

Primary Insurance: _____

Subscriber's name: _____

Subscriber's DOB: _____

Subscriber's SS#: _____

Account # _____

Secondary Insurance: _____

Subscriber's name: _____

Subscriber's DOB: _____

Subscriber's SS#: _____

Account # _____

INSURANCE /MEDICARE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage listed above. I assign directly to Association of Behavioral Counselors Pllc (ABC) all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

ABC may use my health care information and may disclose such information to my insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Beneficiary, Guardian, or Personal Rep.

_____
Print name of Beneficiary, Guardian or Personal Rep.

_____ _____
Date Relationship to Patient

*****RECENT HIPPA LAWS REQUIRE THAT WE ASK THE FOLLOWING*****

Should medical records need to be released, who may we release these records to?

☐ Another doctor's office ☐ Employer ☐ Other Name: _____

Note: *If not indicated, then patient must come by the office and sign a release before records can be sent.*

May a family member (spouse/children/etc.) pick up these records if patient is unable to? Yes ☐ No ☐

We have your permission to contact you to provide appointment reminders. Messages may be left with the person answering the telephone, answering machine, voicemail, or email, if you are not available.

Signature: _____ Date: _____

Continued on back ⟶

Family members living with you:

NAME and AGE	RELATIONSHIP	NAME AND AGE	RELATIONSHIP

PRIOR COUNSELING, MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT? YES ☐ NO ☐

IF YES: NAME OF PROVIDER: _____ CITY/STATE _____

DATE LAST SEEN: _____ / _____ / _____

NAME AND LOCATION OF PRIMARY CARE PHYSICIAN OR NURSE PRACTITIONER:

_____

MAY WE CONTACT YOUR PRIMARY CARE PHYSICIAN OR NURSE PRACTITIONER? YES ☐ NO ☐

IF YES, SIGN HERE: _____ DATE: _____

CURRENTLY ON MEDICATION: NO ☐ YES ☐

_____	DOSAGE: _____	_____	DOSAGE: _____
_____	DOSAGE: _____	_____	DOSAGE: _____
_____	DOSAGE: _____	_____	DOSAGE: _____
_____	DOSAGE: _____	_____	DOSAGE: _____
_____	DOSAGE: _____	_____	DOSAGE: _____

ARE THERE ANY MEDICAL CONDITIONS (INCLUDING ALLERGIES) THAT WE NEED TO BE AWARE OF?

_____

DO YOU OR HAVE YOU EVER ABUSED ALCOHOL OR DRUGS: YES ☐ NO ☐

BRIEFLY DESCRIBE THE REASON YOU ARE SEEKING COUNSELING: _____

_____

PAYMENT/INSURANCE AGREEMENT & AUTHORIZATION TO SEND REIMBURSEMENT INFORMATION

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the therapist agrees otherwise. I understand that, unless the above named patient has coverage under a managed health plan (e.g., HMO, PPO, EAP, HRA, etc.) in which the therapist is a participating provider, I am personally responsible for the payment of all charges. I understand that, as a courtesy, the provider will file insurance claims for the services provided' however, this does not release me of my responsibility for payment of the charges for services. Payment for any charges denied or not covered by my insurance company becomes my responsibility and I agree to pay these charges. I also understand that any court order I have is an agreement between myself and the courts, NOT the provider, and I am still responsible for payment of all charges. I understand and agree that I may be charged for and required to pay for missed appointments that are not cancelled at least 24 hours in advance. I further understand that a collection agency and/or the courts may be used in the event of delinquent payment, and I realize that such action could require that the provider release to the collection agency, attorneys, and or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed. In addition, IF I have requested that the provider file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans in the future may require that the provider provide the plan management with confidential patient information, including diagnoses and the dates and type of services rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the provider to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

Signature: _____ Date: _____