PATRICIA OLIVER SPROUSE, LCMHC

301 N. 2nd St., Mebane, NC 27302

Dear Client/Guardian:

All major health insurers and Medicaid require me to obtain patient information. I apologize for the time required to complete these forms and thank you for your cooperation.

Please Print Clearly

Client Name:_____

Address: _____

_____

Primary Phone #:_____ Alt. Phone #_____

Email address:_____

Occupation / Employer: _____

Social Security Number _____/_____/_____ Birth date:_____

Referral Source: _____ Contact Person:_____

Emergency Contact Person / Relationship_____

Phone Number:_____ Alt. Number_____

Referring Physician (for those 21yrs & younger with Medicaid):_____

Phone Number:_____ Physician NPI:_____

Medications: (with dosage and frequency)_____

_____

_____

Marital Status: Single Married Widowed Divorced Separated How long?_____

Primary Language:_____ Race: _____

Do you have any allergies? ☐ No ☐ yes, list and give reactions:_____

_____

_____

Guardian Name/relationship:_____

Address: _____

Home Phone #:_____ Alt. Phone # _____

GUARANTOR INFORMATION (If different from client) :

Name:_____Relationship:_____

Address:_____

SS#_____/_____/_____ Date of Birth: _____/_____/_____

Employer:_____

Client Name:_____ Med. Record #_____

Insurance Information: (complete the following if copy of card is not available)

Policy Holder's Name:_____DOB:_____ SS# _____

Company:_____

Policy Number:_____ Group #_____

Claims Address:_____

Claims Phone Number:_____

Include Prescription Drug Coverage? ☐ No ☐ Yes

2nd Insurance: (complete the following if copy of card is not available)

Policy Holder's Name:_____DOB:_____ SS# _____

Company:_____

Policy Number:_____ Group #_____

Claims Address:_____

Claims Phone Number:_____

Include Prescription Drug Coverage? ☐ No ☐ Yes

In order to establish optimal relations with my clients and avoid misunderstanding regarding our payment policies, please refer to the Client-Therapist Services agreement for my financial policies. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICES FOR "YOUR PART" OF THE CHARGES. Your signature below indicates that you understand and accept this policy.

CONSENT FOR TREATMENT / INSURANCE AUTHORIZATION

I hereby authorize treatment by Patricia Oliver Sprouse, LCMHC

I hereby authorize Patricia Oliver Sprouse, LCMHC to furnish information to my primary care physician, insurance and/or Medicaid, or County LME (such as Cardinal Innovations) concerning my diagnosis(es) and treatments. I understand that I am responsible for all fees regardless of insurance coverage. I further authorize Insurance benefits to be paid directly to Patricia Oliver Sprouse, LPC.

Signature:_____ Date:_____

Do we have your permission to:

Leave a message on your answering machine at home? ☐ No ☐ Yes ☐ N/A

Leave a message at your place of employment? ☐ No ☐ Yes ☐ N/A

Discuss your medical condition with any member of your household? ☐ No ☐ Yes ☐ N/A

(If yes, additional "Release of Information" forms are required)

Signature:_____ Date:_____