Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Date of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (if minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (name and Phone #): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can I thank them for the referral? \_\_\_\_\_\_\_\_\_\_\_\_ Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAYER INFORMATION** (\**Insurance Company, EAP, or self-pay*):

|  |  |
| --- | --- |
| \*Name of *Primary* Payer: | \*Name of *Secondary* Payer: |
| Contact Information (800#, Payer ID, PO Box from card):  | Contact Information (800#, Payer ID from card): |
| Primary Policy Holder (PPH) Name:  | Secondary Policy Holder (SPH) Name:  |
| PPH Date of Birth: | SPH Date of Birth: |
| PPH Phone Number:  | SPH Phone Number:  |
| PPH Address:  | SPH Address:  |
| Policy Group # | Policy Group # |
| Plan #/Type:  | Plan #/Type:  |
| Employer:  | Employer:  |
| Annual Deductible: Amt. Met: | Annual Deductible: Amt. Met: |
| Session Copayment Amt.:  | Session Copayment Amt.:  |
|  Or Coinsurance (%):  |  Or Coinsurance (%):  |
| Pre-Authorization neededIf so, Auth #: # sessions authorized:  | Pre-Authorization needed? If so, Auth #: # sessions authorized: |

**CLIENT INITIALS AND SIGNATURE:**

 \_\_\_\_\_I am giving permission to contact my *emergency contact person* in the event of a medical emergency.

 \_\_\_\_\_I have been provided with information, and/or have read, policies relating to the *privacy of my health records*, and am aware that I may have a copy of this policy to take with me at my request.

\_\_\_\_\_I have been given and have read *the financial policy* of Sherry Hubbard, LIMHP/Great Plains Counseling, LLC. I understand that I may have a copy of this policy to take with me at my request, and consent to filing of claims and statements sent related to services rendered. I agree that I am financially responsible for services rendered.

\_\_\_\_\_I have been given and have read *information regarding my treatment/sessions* with Sherry Hubbard, LIMHP, MFT, PC, and consent to treatment.

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_