New Client Data

The SUMMIT Therapy Center of Wooster, LLC
4419 Cleveland Rd., Wooster, OH 44691
Ph: (330) 345-8450 FAX: (330) 345-5899

Please print clearly and fill all sections out COMPLETELY. Thank you!

Date: _____

Patient

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Sex (M or F): _____

Phone: _____ Yours or Parent's? (circle) Email: _____

Birth Date: _____ SSN: _____

Employer _____ Address: _____

Occupation: _____ Education Completed: _____

Family Physician: _____ Where: _____

Have you ever seen a mental health professional before? _____ When? _____
Please list current allergies, medication/dosages, and conditions being treated:

_____

Primary Insurance? (Y or N) **Secondary Insurance?** (Y or N) **EMPLOYER:** _____

Who is the Subscriber of Insurance? _____

Subscriber Address: _____

Subscriber's Birth Date: _____ **Subscriber's SSN:** _____

Insurance Company: _____ ID: _____ Group: _____

NO SHOW POLICY: You will be charged $50.00 for any missed appointments that are not cancelled 12 hours prior to your appointment. Insurance does not provide coverage for missed appointments.

Responsible Party (if not the client or insurance subscriber):

Name: _____ Address: _____

Phone: _____ Relationship to Client: _____

Emergency Contact: _____ Phone: _____

Who may we thank for referring you to us? _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for payment of any professional services rendered. I hereby authorize The SUMMIT Therapy Center to disclose any protected health information of named individuals listed above to receive payment of medical benefits for service rendered by The SUMMIT Therapy Center staff. I certify that the above information is true and correct to the best of my knowledge. I will notify The SUMMIT Therapy Center of any changes to the above information.

Client/Guardian: _____ Therapist _____ Date: _____