CLIENT INFORMATION

NAME (Last, First, Middle)		**PHONE**
ADDRESS (Number, Street, City, State, Zip)		**EMAIL**
DATE OF BIRTH	**AGE**	**GENDER** (as recognized by your insurance company) □ **MALE** □ **FEMALE**
EMERGENCY CONTACT INFORMATION		
PRIMARY CARE PHYSICIAN		**PSYCHIATRIST** (if applicable)
CURRENT MEDICATIONS (if applicable)		
REFERRED BY		**PREFERRED REIMBURSEMENT** □ Insurance □ Self pay □ Self pay with superbill

Acknowledgment and Authorization

(to be completed by the insurance subscriber)

□	I authorize the release of any medical or other information necessary to process claims. I understand that, in order to process claims, some of my personal health information will be sent electronically to my insurance company.
□	I understand that insurance reimbursement is based on “medical necessity” and that “medical necessity” is primarily determined by the assignment of a medical/psychiatric diagnosis.
□	I understand that “medical necessity”, for the sake of reimbursement, is ultimately determined by the insurance company.
□	I understand that the provider's role with the insurance company *will be limited to claim submission and completion of Outpatient Treatment Request forms, when required*. I agree that any other communication with the insurance company is solely my responsibility.
□	I agree to reimburse the provider directly in the event that insurance does not authorize reimbursement, either before, during or after services are rendered.
□	I understand that copay, coinsurance and deductible payments are due prior to or at the time that services are rendered.
SUBSCRIBER SIGNATURE AND DATE	

Insurance Information

(to be completed by provider)

INSURANCE COMPANY	**PLAN NAME**
PRIMARY MEMBER	**MEMBER ID#**
ANTICIPATED COPAY/COINSURANCE/DEDUCTIBLE	**SECONDARY INSURANCE**