Laura Manuppelli, Ph.D.
Practice of Psychotherapy, LPC, LMFT

Today's Date: _____

Clinical Information

Please fill out all sections that apply to your life situation.

Name(s) of Person(s) Seeking Therapy:_____

Name of Person Completing this Form:_____

Patient's Information:

Address:_____City:_____Zip:_____

Home phone:_____Office phone:_____

Cell phone/Beeper:_____ E-mail:_____

Referred by:_____

Occupation:_____ Place of Business:_____

Date of Birth:_____ Soc. Sec. #:_____

Education(# of years completed or degree achieved):_____

Marital Status (Circle One) Single Married Divorced Separated Widowed

For how long have you been married, divorced, etc.:_____

Have either you or your spouse been married before?:_____

How long were each of you married to ex-spouse(s):_____

List names, ages sex, and dates of birth for each of your children:

1. Name:_____age:_____DOB:_____Sex:_____
2. Name:_____age:_____DOB:_____Sex:_____
3. Name:_____age:_____DOB:_____Sex:_____

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With whom do your children live?:_____

Do you have step children?:_____ If yes, do the live with you?:_____ what are their names and

ages:?_____

_____

Spouse's Information:

Name:_____

Address:_____Zip:_____

Date of Birth:_____Soc. Sec. #_____

Home Phone:_____ Office Phone_____

Cell Phone/Beeper:_____ E- mail:_____

Occupation:_____ Place of Business:_____

Education (# of years completed or degree achieved):_____

Parent's Information (Fill out this section only if you are under 18 years old or if you are living with your parents):

Mother's

Name:_____

Mother's Address(if different from yours):_____

City:_____State:_____Zip:_____

Date of Birth:_____Soc. Sec. #_____

Home Phone:_____

Mother's Occupation:_____ Place of Work:_____

Work phone:_____ Cell phone:_____

Father's Name:_____

Father's Address(if different from yours):_____

City:_____State:_____Zip:_____

Date of Birth:_____Soc. Sec. #_____

Home Phone:_____

Father's Occupation:_____ Place of Work:_____

Work phone:_____

Please list all persons who live in your household and their relationship to you.

_____

_____

_____

_____

Basic Health

Health condition: Good___ Fair___ Poor____ When was your last physical exam?_____ Who is your physician?_____

Are you taking any prescription medication(s) at this time? Yes ___ No ____

If yes, name the medication(s) and the condition(s) for which they are prescribed:_____

_____

Do you have any physical, emotional, or mental condition including substance abuse now or in the past of which I need to be aware? Yes_____ No____ If yes, please describe

_____

_____

Have you ever been hospitalized? Yes____ No ____ If yes, for what reason?

_____

_____

Have you, yourspouse, or anyone in your immediate family ever been in therapy before?_____ If yes, what were the circumstances?

_____

_____

When and for how long? _____

What is the name of the person seen for therapy?_____

Does any other member of your family have any physical, emotional or mental condition including substance abuse now or in the past of which I need to be aware? Yes___ No__

If yes, please describe:

_____

_____

Spouses Basic Health:

Health condition: Good___ Fair___ Poor____ Date of last physical exam?_____ Physician's Name?_____

Physician's phone:_____ Is your spouse taking any prescription medication(s) at this time? Yes ___ No ____If yes, name the medication(s) and the condition(s) for which they are prescribed:_____

_____

Spouse's physical, emotional, or mental condition including substance abuse now or in the past of which I need to be aware? Yes_____ No____ If yes, please describe

_____

_____

Spouse's hospitalizations (if any) and reasons:_____

_____

Reason(s) For Seeking Therapy:

Briefly describe the problem for which you wish to have therapy?

_____

_____

_____

What would you like to see happen as a result of therapy?

_____

_____

_____

I understand that all therapeutic information is confidential except in circumstances where there is an indication that I am a danger to myself or others.

I understand that suicidal threats, homicidal threats, or child abuse by an adult to a child must be reported as dictated by law and as required by Texas State Licensing Boards.

I give permission to my therapist to seek professional consultation with colleagues about my situation when necessary, given my identity will be kept confidential at all times. Yes ____ No _____

(please initial one)

Signatures:

Patient:_____ Date:_____

Parent:_____ Date:_____

Spouse:_____ Date:_____

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Today's Date: _____

Insurance and Payment Information Form

I truly appreciate your choosing me for psychotherapy services. As part of providing high quality services, we need to be clear about our financial arrangements

- If you have health insurance, it may pay for part of the cost of your treatment here. To find out if this is so, my billing staff and I need the information request below. I will explain any part of this for that you do not understand.
- If you have no health insurance coverage, or do not intend to use it, please check here__; complete sections A and D below, sign on page 3, and return this form to me.

A. Patients name:

Last:_____ First:_____ MI:_____

Birth date:_____ Soc. Sec.#_____

Address:_____City:_____Zip:_____

Home phone:_____Office phone:_____

Cell phone:_____ E-mail:_____

Insured's/Policy holders name:_____

Relationship to patient:_____

Address (if different from patient's)_____

_____

Occupation:_____ Employer:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Address of Employer:_____

Soc. Sec # _____ Birthdate:_____

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B. (If applicable) Spouse's name:_____

Home phone:_____Work Phone:_____

Birthdate:_____ Soc. Sec #_____

Occupation:_____ Employer:_____

Address of Employer:_____

_____

C. If you (or your spouse/parent) have any type of insurance benefits please fill in the name and numbers of them.

1. Name of Health Insurance: _____

2. Name of subscriber:_____

   Policy # _____ Group # _____

   Effective date: _____

   Mailing address for claims: _____

   City _____ State _____ Zip _____

   Insurance Phone # _____

D. If you do not have insurance, how will you pay for services from this office?

_____

_____

E. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the billing assignee or myself

F. I understand that I am responsible for all charges, regardless of insurance coverage.

G. I understand that the fee for psychotherapy services is $150.00 per 45-50 minute session unless other insurance benefits, managed care, or EAP agreements apply. Fees and co-payment are due at time of serve. It is illegal to waive co-payment charges.

H. I understand that a notice of 2 full business days in advance of my appointment is required and appreciated; otherwise usual fee will be charged.

CANCELLING APPOINTMENTS WITHIN THE NOTICE OF 2 FULL BUSINESS DAYS PERTAINS TO BUSINESS DAYS AND HOURS WHICH ARE:

MONDAY THRU THURSDAY FROM 8 A.M. TO 5 P.M. AND FRIDAYS FROM 8 A.M. TO 12 NOON.

CANCELLING A SCHEDULED APPOINTMENT ON WEEKENDS HOLIDAYS, AND AFTER THE BUSINESS HOURS NOTED, IS NOT INCLUEDED IN THE 2 DAY WINDOW. THE REQUIRED TWO BUSINESS DAY CANCELLATION TIME FRAM PERTAINS TO 2 FULL DAYS WITHIN THE BUSINESS HOURSA AS NOTED ABOVE

I. assignment of benefits:
I hereby assign medical benefits, including those from government sponsored programs and other health plans, to be paid to the therapist above. A photocopy of this assignment is considered as good as the original. PLEASE BE SURE TO PROVIDE MY OFFICE WITH A COPY OF ALL INSURANCE CARDS FOR WHICH YOU WOULD LIKE US TO FILE INSURANCE, AND UPDATES AS APPROPRIATE.

_____ _____

Client's (or parent/guardian's signature) Date
Indicating agreement to all statements
Above

_____

Printed Name

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Policy Terms of Sessions, Payment and Cancellations

- Therapy sessions are 45-50 minutes long, so please be on time to complete a full session.
- All payments must be made at the beginning or close of each session. (It is illegal to refuse collection of co-payments, and we are not set up to send statements for payments due at time of service).
- **A notice of 2 full business days is required and appreciated. Regular fee will be billed to you for last minute cancellations or "no-shows". This policy is enforced by the Doctors Office Manager.**
- **CANCELLING APPOINTMENTS WITHIN THE NOTICE OF 2 FULL BUSINESS DAYS PERTAINS TO BUSINESS DAYS AND HOURS WHICH ARE**:
- **MONDAY THRU THURSDAY FROM 8 A.M. TO 5 P.M. AND FRIDAY FROM 8 AM TO 12 NOON.**
- **CANCELLING A SCHEDULED APPOINTMENT ON WEEKENDS, HOLIDAYS AND AFTER THE BUSINESS HOURS NOTED ABOVE IS NOT INCLUDED IN THE 2 DAY WINDOW. THE REQUIRED 2 BUSINESS DAY CANCELLATION TIME FRAMPERTAINS TO THE BUSINESS HOURS AS NOTED.**

I, the undersigned, have read, understand, and agree to the terms of this business policy as stated above.

_____	_____	_____
Client Signature	Printed Name	Date
_____	_____	_____
Witness	Printed Name	Date

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