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 form:_____

Patient's Information:

Address:_____City:_____State:___ Zip:_____

Home Phone:_____Office Phone:_____Mobile Phone: _____

Email: _____

Referred by: _____

Occupation:_____Place of business: _____

Date of birth:_____Soc. Sec. #:_____

Education (# years completed or degrees achieved): _____

Marital Status (circle one): Single Married Divorced Separated Widowed.

If Married, for how long?:_____

If Divorced, for Howlong?:_____

How long were each/either of you married?:_____

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:_____
4) Name: _____Age: _____DOB:____Sex:_____

With whom do your children live?:_____

Do you have step children?:_____if yes, do they live with you?: _____

What are their names and ages?:

_____

_____

Spouses Information:

Name: _____

Address:_____City:_____ State:____Zip: _____

Date of birth:_____Social Security Number: _____

Home phone:_____Office phone:_____Mobile phone:_____ Email: _

Occupation:_____Place of business: _____

Education (# of years completed):_____

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

_____

Mothers Information:

Name: _____

Address:_____City:_____ State:____Zip: _____

Date of birth:_____Social Security Number: _____

Home phone:_____Office phone:_____Mobile phone: _____

Email: _____

Occupation:_____Place of Work: _____

Fathers Information:

Name: _____

Address:_____City_____ State___Zip: _____

Date of birth:_____Social Security Number: _____

Home phone:_____Office phone:_____Mobile phone: _____

Email: _____

Occupation:_____Place of business: _____

Please list all persons who live within your household and their relation to you:

_____

_____

_____

_____

Basic Health:

Health condition (please circle one): Good Fair Poor

When was your last physical: _____Who is your physician: _____

Physician contact info:_____ Are you taking any

prescription medication at this time: _____

If yes, name the prescribed 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(please circle one): Yes No

If yes, please describe:

_____

_____

Have you ever been hospitalized (please circle one): Yes No

If yes, for what reason(s):

_____

_____

Have you, your spouse, or anyone in you immediate family ever been in therapy before (please circle one): Yes No

If yes, what were the circumstances?

_____

_____

_____

When and how long: _____

What is the name of the person you saw 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 (please circle one): Yes No

If so who:_____ and for what Treatment:_____

_____

_____

_____

_____

Spouses Basic Health:

Health condition(please circle one): Good Fair Poor

Date of last physical exam:_____Physician's name: _____

Physicians #:_____Is your spouse taking any prescription medications at this time: Yes No

If yes please name the medications and conditions in which they are prescribed:

_____

_____

_____

_____

Spouses physical, emotional or mental condition including substance abuse now or in the past of which I need to be aware:

_____

_____

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 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 the 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

Signature(s):

Patient:_____Date: _____

Parent:_____Date: _____

Spouse:_____Date: _____

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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 on our financial arrangements.

If you have health insurance, it may pay for part of the cost of your treatment, therefore I need information requested below. I will explain any part of this form 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: _____

Birthdate:_____Soc. Sec. #:_____

Address: _____

City:_____State:_____Zip: _____

Home phone:_____Work phone: _____

Email: _____

Insured/Policy holders name: _____

Relation topatient: _____

Address (if different):

_____

_____ Occupation:

_____Employer: _____

Address of Employer:

_____

_____ Soc. Sec. #:

_____Birthdate: _____

B. If you or your spouse/parent have any type of insurance benefits, please fill the information that follows:

Name of Health Insurance: _____

Name of subscriber (primary insured): _____

Policy #:_____Group#:_____

Effective date: _____Mailing address for claims:

_____City:_____State:_____Zip: _____

Insurance phone #:_____

C. If you do not have insurance, how will you pay for services from this office:
(Please identify name of person responsible for paying Dr. Manuppelli's fees and their relationship to you)

_____

_____

_____

D. I give this office permission to release any information obtained during examination or treatment of this patient that is necessary to support an insurance claim on this account and secure timely payments due to the billing assignee or myself. This permission extends to correspondence between this office and persons named responsible (section "C" above) for payment and services provided. This permission will also extend to any legal or collections entities.

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

F. I understand that the fee for psychotherapy is $175 per 45-50-minute session unless other insurance benefits, managed care, or EAP agreements apply. Fees and copayments are due at the time of service. It is illegal to waive co-payment charges.

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

CANCELLING APPOINTMENTS WITHIN THE NOTICE OF 2 FULL BUSINESS DAYS PERTAINS TO BUSINESSDAYS 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 ABOVE, IS NOT INCLUDED IN THE 2 BUSINESS DAY WINDOW. THE REQUIRED TWO BUSINESS DAY CANCELLATION TIME FRAME PERTAINS TO 2 FULL DAYS WITHININ THE BUSINES HOURS AS NOTED ABOVE.

A. Assignments 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 WHICHYOU 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 to 50 minutes long, 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 copayments 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 nd hours which are:**
- **Monday thru Thursday from 8 A.M. to 5 P.M. and Friday from 8 A.M. to 12 noon.**
- **Cancelling a scheduled appointment on weekends, holidays, and after the business hours noted above is not included in the 2 business day cancellation time frame.**

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