

Adult Information Form

Office Use: ID verified: _____ Type: _____

Information About You

v8.2.10a

Name: _____ Today's Date: _____

Mailing Address: _____ City, State, Zip _____, _____, _____

Home Phone: _____ Cell Phone: _____ Date of Birth: ____/____/____

Occupation: _____ Work Phone: _____ Employer: _____

Sex: _____ Relationship Status: _____ Partner's Name: _____ # of Children: _____

Who is your current physician? _____ City: _____

List any major medical problems: _____

Medications and dosages: _____

use back if needed, or provide a list of your own

Is it OK to call and leave messages at home? Yes No | On your cell? Yes No | At work? Yes No

If you have Caller ID, would you like us to block our name when calling your home? Yes No Does not apply

Whom can we call in case of emergency? _____ Phone # (____) _____ - _____

If not yourself, provide the name of person responsible for payment on your account: (The person signing this form)

Self Other: _____

Social Security Number of above-named person: _____--____--_____

Why we need your Social Security Number (SSN): If you are not paying cash in full, your clinician becomes a business offering you credit and carrying outstanding balances on your behalf. Having your SSN (or that of the financially responsible party) allows correct identification of the person responsible for your account. Your SSN is kept secure. Not providing this number assumes you are planning to pay cash in full at time of each service.

How do you prefer to cover your expenses? Cash Insurance Employee Assistance Medicare Other _____

If insurance, name of primary insurance carrier: _____

Note: Please present your insurance card so that we may make a copy for our records.

If you have dual coverage, provide us **both** cards and clarify which is primary and which is secondary.

Name of subscriber (if not yourself): _____ Subscriber's date of birth: _____

Your relationship to the subscriber: self spouse child Other: _____

Subscriber's Policy or Health Record Number: _____ Group Number: _____

Co-pay amount _____ (\$ or %) Subscriber's Employer: _____

Who referred you to our office? _____

Your clinician wants to ensure that he or she is providing the best care possible based on your particular culture and language preference. Please complete the following information: (check one)

Asian American Indian or Alaska Native Black or African American Native Hawaiian or Pacific Islander

White/Caucasian More than one race Are you Hispanic or Latino? Yes No

Do you prefer to communicate in a language other than English? Yes No - If yes, which? _____

Places For You to Sign

There are three areas where we need your signature. These include: 1) your acknowledgement of having received information about your clinician, office policies, and protecting the privacy of your healthcare record, 2) allowing your clinician to speak with your medical doctor, and 3) allowing us to bill your insurance for services.

1. I have been provided information regarding office policies, including fees, policies regarding missed appointments and late cancellations, the right to refuse treatment, choosing the best treatment provider, and protecting the privacy of my healthcare record.



Signature

Date

2. I prefer to work as a team with your regular physician. In fact, some insurance companies require your primary care physician to be informed of your mental health treatment.

I give my permission for my clinician to speak with my primary care physician under the following conditions:

Check one box

- I don't have a primary care physician, or this issue doesn't apply to me.
- I prefer my physician **not** be contacted about my evaluation or treatment.
- My clinician can communicate only basic information about my visits here, using his/ her own discretion, including dates of visits, kind of treatment, and when treatment ended.
- My clinician can communicate any and all information about my visits, as needed.



Signature

Date

3. If you plan to use insurance benefits to help cover evaluation and treatment costs, you will need to allow us to communicate with your insurer. **There is no need to sign if you are not using health insurance to cover costs.** Your signature below allows:

- Your clinician to release basic, confidential information about you, such as date and type of service, diagnosis, and other information required to process your claim;
- Your insurance company to pay benefits directly to your clinician to be applied to your account;
- Your clinician to bill your insurance company in the future without you having to sign for this each time.

I understand that I am responsible for any charges not covered or reimbursed by my insurer. Also, I understand that this authorization is valid until withdrawn by me in writing, and that I may revoke this release at any time except to the extent that action has already been taken in reliance on my consent.



Signature

Date