PSYCHOLOGICAL STRATEGIES, LLP
APPLICATION FOR SERVICES

Referred By: _____ Date: _____

Patient Name: _____ Age: _____ Gender: Male Female

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code _____

OK to send mail to this home address: _____ (initial)

If no, where may we send mail _____

E-mail: _____ OK to send e-mail appointment confirmations? _____ (initial)

Home Phone: _____ OK to leave a message: _____ (initial)

Work Phone: _____ OK to leave a message: _____ (initial)

Cell Phone: _____ OK to leave a message : _____ (initial)

Other Phone: _____ OK to leave a message: _____ (initial)

Occupation: _____ Place of employment: _____

Current Marital Status: (circle) Single Married Living as married Separated Widowed

Emergency Contact: Name: _____ Relation to you: _____

Address: _____ Phone: _____

If Child:
Mother's Name: _____ Mother's D.O.B.: _____

Father's Name: _____ Father's D.O.B.: _____

Parents are: (circle) Married Separated Divorced Widowed Never Married

Primary Physician: _____ Phone: _____

Address: _____ City _____ State: _____Zip: _____

Previous mental health contact for self or family members: _____

Current medications: Prescribed By:

_____ _____

_____ _____

_____ _____

There is a possibility my case will involve court proceedings: Yes _____ No _____

I authorize Psychological Strategies, L.L.P. to send informational mailings to my home address:

Signature: _____ Date: _____

I hereby apply for and consent to psychological therapy, consultation and/or testing. I understand that it is my responsibility to cooperate with treatment. My signature here certifies my consent that my therapist may use/share my Protected Health Information as described in the HIPAA PRIVACY NOTICE I have received.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

I authorize payment of medical benefits to _____ for services rendered. If a problem occurs with the insurance company regarding payment of medical benefits, the patient is responsible for payment of the medical benefits for services rendered in our office. All follow-ups with the insurance company will be the responsibility of the patient.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Charges for services are due and payable at the time services are rendered, unless prior arrangements have been made with the therapist. If you have health insurance, it should be understood that this is an agreement between you and your insurance company to pay you certain amounts for medical care. Your therapist's bill is an agreement between you and your therapist. You are responsible for payment of your bill, regardless of the status of your insurance claim. Insurance companies have a schedule of fees which they will pay. Your therapist's fees may be more or less than this actual schedule. If you fail to meet your financial responsibilities, your account may be turned over to a collection agency or the appropriate court. I hereby give my consent to release necessary information for taking such action. The patient is responsible for any fees or expenses incurred because of collection or court actions.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

I hereby assume financial responsibility for all charges that may be incurred for treatment rendered to myself and/or my family member(s). I understand the financial policy described above. I have also read and understand the Patient Rights and Responsibilities and the HIPAA Notice of Privacy Practices. I have received a copy of both forms to retain for my records.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Witness: _____ Date: _____