



## PATIENT INFORMATION

### PERSONAL INFORMATION:

PATIENT NAME: \_\_\_\_\_ SEX: \_\_\_M\_\_\_F  
SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PH: \_\_\_\_\_ ALT #: \_\_\_\_\_ CELL #: \_\_\_\_\_  
MARITAL STATUS: M S W D  
STUDENT: Y N NAME OF SCHOOL \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION:

INSURANCE COMPANY NAME: \_\_\_\_\_  
ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
NAME OF SUBSCRIBER: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: PARENT SPOUSE OTHER  
SUBSCRIBER SOCIAL: \_\_\_\_\_ DOB: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION:

INSURANCE COMPANY NAME: \_\_\_\_\_  
ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
NAME OF SUBSCRIBER: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: PARENT SPOUSE OTHER  
SUBSCRIBER SOCIAL: \_\_\_\_\_ DOB: \_\_\_\_\_

### RESPONSIBLE PARTY:

NAME: \_\_\_\_\_ SEX: \_\_\_M\_\_\_F  
SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ ALT #: \_\_\_\_\_  
MARITAL STATUS: M S D W  
RELATIONSHIP TO PATIENT: PARENT/GUARDIAN SELF OTHER

*Health Care insurance is a contract between you and your insurance company. It is the patient's responsibility to know their policies and see that we get the proper referrals prior to their visit. All co-payment amounts are due at the time of service, you are responsible for deductibles and any applicable expenses your insurance does not cover. By signing this agreement you are allowing this office to release any mental health information necessary to process your claims and to also authorize payment of mental health care to Anchor Psychological & Counseling Services, PLLC for services rendered.*

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT:**

**ALL NON-TRICARE:**

I request that payment of authorized insurance benefits be made on my behalf to **Anchor Psychological & Counseling Services, PLLC** for any services furnished to me by them. I authorize any holder of medical/psychotherapy information about me to be released to the health care finance administration and its agents and any information needed to determine these benefits or benefits payable to related services.

I authorize by signature that payment be made, and I authorize release of medical/psychotherapy information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurance or agency shown. Insurance assigned cases, the physician or supplier agrees to accept the charge determination of insurance carriers as the full charge and the patient is responsible only for the deductible, co-insurance(s), and the deductible based upon the charge determination of the insurance carrier. Non-covered services require a separate form.

\_\_\_\_\_  
Beneficiary and/or Parent Guardian Signature

\_\_\_\_\_  
Date

**Tricare-** “I request that payment of authorized benefits be made on my behalf to **Anchor Psychological & Counseling Services, PLLC** for any services furnished to me by that organization. I authorize any holder of medical/psychotherapy information about me to be released to Health Net and its agents for any information needed to determine these benefits or the benefits payable for related services.”

\_\_\_\_\_  
Beneficiary and/or Parent Guardian Signature

\_\_\_\_\_  
Date

**NO SHOW/CANCELLATION FEE:**

I UNDERSTAND THAT IF I CANNOT KEEP AN APPOINTMENT, I MUST CANCEL TWENTY-FOUR (24) HOURS PRIOR TO THE APPOINTMENT OR I WILL BE CHARGED A “NO SHOW” FEE OF FIFTY DOLLARS (\$50.00)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**CONSENT TO TREAT AGREEMENT:**

**\*\*\*\*\*MUST BE SIGNED TO RECEIVE TREATMENT\*\*\*\*\***

BY MY SIGNATURE HEREIN, I AFFIRM THAT I AM THE PATIENT \_\_\_\_\_  
**(PARENT/LEGAL GUARDIAN OF)** AND I HEREBY ACKNOWLEDGE THAT I AUTHORIZE AND GIVE PERMISSION TO THE STAFF OF ANCHOR PSYCHOLOGICAL & COUNSELING SERVICES, PLLC, TO RENDER TREATMENT AND/OR SERVICES TO MYSELF/ABOVE NAMED MINOR, AND I HEREBY ACKNOWLEDGE THAT STAFF IS RESPONSIBLE FOR TREATMENT AND/OR SERVICES RENDERED IN THE COURSE OF TREATMENT (THERAPEUTIC TIME IN FACILITY) AND CANNOT BE HELD RESPONSIBLE FOR MY BEHAVIOR/BEHAVIOR OF MINOR CHILD OUTSIDE OF THE CONTEXT OF THE THERAPEUTIC TREATMENT SESSION.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**PATIENT QUESTIONNAIRE**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

HAVE YOU SOUGHT TREATMENT FOR THIS PROBLEM BEFORE? \_\_\_\_\_

IF SO, WHEN? \_\_\_\_\_ WHERE? \_\_\_\_\_

WHO REFERRED YOU TO THIS CLINIC? \_\_\_\_\_ HAVE YOU SOUGHT  
TREATMENT FOR ANY MENTAL HEALTH/EMOTIONAL PROBLEMS  
BEFORE? \_\_\_\_\_ IF SO, PLEASE EXPLAIN

\_\_\_\_\_ -

PLEASE LIST AND DESCRIBE ANY SIGNIFICANT MEDICAL HISTORY (ILLNESSES, DISEASES, SURGERIES,  
ALLERGIES, ETC.) \_\_\_\_\_

\_\_\_\_\_

PLEASE LIST ANY FAMILY HISTORY OF MENTAL DISORDERS OR MEDICAL CONDITIONS (LIST  
CONDITION AND HOW RELATED.

\_\_\_\_\_

PLEASE LIST EVERYONE WHO LIVES IN YOUR HOME, THEIR AGES, AND SCHOOL/EMPLOYMENT.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHO IS YOUR PRIMARY CARE  
DOCTOR/CLINIC? \_\_\_\_\_

ADDITIONAL RELEVANT INFORMATION:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**ACKNOWLEDGEMENT OF GUARDIAN/CUSTODIAN**

I, (print name) \_\_\_\_\_, certify that I am the  
legal guardian/custodian of (print name): \_\_\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



## PATIENT/CLIENT BILL OF RIGHTS, RESPONSIBILITIES, AND THE LIMITS OF CONFIDENTIALITY

Anchor Psychological & Counseling Services has a written policy identifying their commitment to delivery of client services in a manner that respects the individual's rights and clearly states the patient's responsibilities.

### RIGHTS

Clients have a right to receive information in a clear and concise manner stating the services provided, the practitioners rendering services and knowledge of the treatment plan and options available to them.

1. Clients have a right to expect treatment being rendered with respect, recognition of the dignity and a right to privacy.
2. Clients have a right to participate with the practitioners in determining the most appropriate treatment plan and services, regarding their healthcare.
3. Clients have a right to candid discussions and explanations in decisions related to their treatment and selection/rejection of the most appropriate options, regardless of the cost or benefit of coverage.
4. Clients have a right to voice complaints or request appeals about the services or personnel delivering the services.

### RESPONSIBILITIES

Clients have a responsibility to provide, to the extent possible, information needed in order to deliver care with full knowledge of the client's history, current status and other relevant details.

Clients have a responsibility to comply with the treatment plan and instructions for the care they have agreed to with their healthcare providers.

5. Clients have a responsibility to understand their allowances, requirements and limitations of their selected health carriers.
6. Clients are responsible to provide accurate and current information to the practice representative and healthcare providers to permit timely and just coverage for services rendered.

### LIMITS OF CONFIDENTIALITY

1. You direct the clinician to tell someone else.
2. The clinician determines that the patient is a danger to themselves or others.
3. The clinician receives information regarding child/elder abuse or neglect.
4. The clinician is ordered by a court to disclose information.
5. If required for insurance billing purposes.

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Client/Patient Signature



DATE: \_\_\_\_\_

RE: \_\_\_\_\_ DOB \_\_\_\_\_

Dear \_\_\_\_\_ Facility \_\_\_\_\_

This letter is to inform you that I am currently seeing your patient for outpatient psychotherapy services at Anchor Psychological & Counseling Services, PLLC. At this time, a working diagnosis of

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has been established. In order to provide the highest level of care, our clinic wishes to establish on-going communication with your facility. Should you have questions or concerns, please feel free to contact me at (910) 270-9995.

Sincerely,

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Signature

Printed Name

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I (check one)  do  do not allow Anchor Psychological & Counseling Services, PLLC and my referral source to have on-going communication in order to provide me with the highest level of care. This form expires 12 months from the date signed unless revoked in writing prior to that date.

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Client /Parent/ Guardian Signature

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Date

Therapist Initials: \_\_\_\_\_

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