PSYCHOTHERAPY ASSOCIATES • NEW PATIENT INFORMATION

To help us meet your needs, please fill out this form completely.
If you have questions or need assistance, please ask and we will be happy to help.

____/_____/____
Today's Date

Patient Information

☐ Male ☐ Female ____/_____/____

Name Date of Birth

Address City State Zip

Telephone, Home
May we leave a message with whomever answers? ☐ Yes ☐ No
May we leave a voicemail message? ☐ Yes ☐ No

Email Address

Telephone, Cell
May we leave a voicemail message? ☐ Yes ☐ No

Social Security #

Telephone, Work
May we leave a message with whomever answers? ☐ Yes ☐ No
May we leave a voicemail message? ☐ Yes ☐ No

☐ Full-time Student
☐ Part-time Student

School/College (if patient is student): City State Zip

Referred By (if applicable) Primary Care Physician

I ☐ authorize ☐ decline to authorize communication between my psychotherapist and referral source, if appropriate.

I ☐ authorize ☐ decline to authorize communication between my psychotherapist and primary care physician.

Patient Employer Employer Address

Circle One: Minor Single Married Divorced Separated Widowed

Spouse – Parent – Significant Other

☐ Spouse
☐ Parent/Guardian
☐ Other

Name

____/_____/____
Date of Birth

Address City State Zip

Telephone, Home
May we leave a message with whomever answers? ☐ Yes ☐ No
May we leave a voicemail message? ☐ Yes ☐ No

Email Address

Telephone, Cell
May we leave a voicemail message? ☐ Yes ☐ No

Social Security #

Employer | Employer Address

Telephone, Work

May we leave a message with whomever answers? ☐ Yes ☐ No

May we leave a voicemail message? ☐ Yes ☐ No

Person to Contact in Emergency | Telephone

Person Financially Responsible for Patient's Medical Care: ☐ Self ☐ Other (please specify):

Primary Health Insurance

Do you have Medicare? ☐ Yes ☐ No

Do you have Medicaid? ☐ Yes ☐ No

Insurance Company | Name of Insured Individual

Identification Number | Date of Birth | Social Security Number | Relationship to Patient

Additional Health Insurance

Insurance Company | Name of Insured Individual

Identification Number | Date of Birth | Social Security Number | Relationship to Patient

Health History

Medication Currently Used:

Name	Dosage	Frequency	Prescribed By:

Sources of Past Mental Health Treatment or Counseling:

Name	Dates

Authorizations and Acknowledgments

- I have received a copy of *Welcome to Psychotherapy Associates* which lists my rights and responsibilities as a patient, including my privacy rights under the Health Information Health Insurance Portability and Accountability Act.

- Assignment of Insurance Benefits: I authorize the release of any information relating to all claims for benefits submitted on behalf of myself or my dependents. My signature on this document authorizes Psychotherapy Associates to submit claims and understand that I will be bound by this signature as though I had personally signed the particular claim. I hereby assign directly to Psychotherapy Associates all benefits otherwise payable to me for services rendered. I understand that any insurance benefits received by Psychotherapy Associates on my behalf will be credited to my account in accordance with the above agreement.

- Authorization to Release Information to Nebraska Medical Assistance Program or Its Designees (if applicable): I authorize the release of confidential information regarding my condition and treatment, or that of my dependent, to Nebraska Medicaid representatives and acknowledge understanding that this is a condition of use of my Medicaid mental health treatment benefits.

- I understand and agree that, regardless of my health insurance coverage, I am responsible for the balance of my account for any professional services rendered.

- I understand and agree that I may be charged, at the discretion of Psychotherapy Associates, for any appointment I do not keep and do not cancel at least 24 hours in advance. I acknowledge that charges for no-show or late-canceled appointments are not covered by health insurance and are my responsibility in full.

- I understand and agree that failure to pay the balance of my account in a timely manner may result in release of non-clinical contact and billing information to a collection agency.

- By virtue of providing my e-mail address and/or cellular telephone number, I authorize their use as a means of communication between Psychotherapy Associates and me and acknowledge that Psychotherapy Associates is unable to ensure complete privacy of communication via either means, of via any electronic media through which I communicate with Psychotherapy Associates.

- I authorize the exchange of confidential information regarding my condition and treatment, or that of my dependent, to all Psychotherapy Associates clinicians for the purposes of providing emergency care and treatment continuity.

- Authorization to Treat Minor (if applicable): I authorize treatment of my minor child or ward, named as patient in this document.

- I certify that this information is true and complete to the best of my knowledge. I understand that it is my responsibility to notify Psychotherapy Associates of any changes in the above information.

Signature ______________________________ Date ______________