

NAME OF PATIENT

LAST NAME FIRST INITIAL NICKNAME

ADDRESS

STREET CITY ZIP CODE

DATE OF BIRTH: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

MONTH DAY YEAR

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

SS#: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

SEX: MALE  FEMALE  Check one: MARRIED  DIVORCED  SINGLE  SEPARATED  WIDOWED

YOUR PRIMARY PHYSICIAN: \_\_\_\_\_ WHO IS RESPONSIBLE FOR PAYMENT: \_\_\_\_\_

SPOUSE, PARENT OR GUARDIAN (Circle one)

NAME: \_\_\_\_\_

LAST NAME FIRST INITIAL NICKNAME

ADDRESS: \_\_\_\_\_

STREET CITY ZIP CODE

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

NAMES & AGES OF OTHER LIVING IN HOME: \_\_\_\_\_

Who may I thank you for referring you to me?

REFERRING DOCTOR'S NAME

REFERRING PERSON'S NAME/RELATIONSHIP/PHONE#

Have you or any member of your family been seen here before? \_\_\_\_\_ Who: \_\_\_\_\_

Name of nearest relative not living with the patient or close friend.

Name: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Phone: \_\_\_\_\_

How related? \_\_\_\_\_

INSURANCE INFORMATION:

In order to avoid error or delay in the processing of any insurance claims, it is essential that this section be COMPLETELY FILLED OUT.

Do you have health insurance to cover these services? YES NO (Circle One)

<p><b>PRIMARY INSURANCE</b>  Insurance Company _____  Ins. Co. Address _____  City _____ State _____ Zip _____  Ins. Co Phone _____    Policy Holder _____ D.O.B _____  Social Security No _____  Employer _____  Group No _____ ID No. _____</p>	<p><b>FEE POLICY</b>  Payment is due at the time of service. Insurance is for the purpose of reimbursing the patient. I will gladly help you complete insurance forms although my fee contract is directly with you. My fee for outpatient evaluation or therapy is \$300 per 45-minute session. One hour evaluations or treatment sessions are thus prorated to \$400. I will bill for appointments canceled less than 24 hours in advance. If you have any questions concerning your bill or insurance, please discuss these with me.</p>
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CONSENT TO TREATMENT AND UNDERTAKING TO PAY FEES

I authorize Dr. Leifeste and/or his associates to perform psychiatric diagnostic evaluation and treatment. I agree to be responsible for full payment of all fees, especially for services not covered by my insurance (i.e. further diagnosis, treatment, phone calls, review of records, session time beyond 45 minutes, etc.). I agree to allow Dr. Leifeste to release my billing information (including diagnosis) to a third party for purposes of collection and agree to pay all costs of collection including reasonable attorneys' fees.

SIGNATURE OF RESPONSIBLE PARTY \_\_\_\_\_

DATE \_\_\_\_\_