MARK LEIFESTE, M.D. PATIENT INFORMATION DATE_____

PLEASE FILL OUT THIS FORM COMPLETELY AND SIGN WHERE INDICATED—PLEASE PRINT

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 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)

PRIMARY INSURANCE	FEE POLICY
Insurance Company_____ Ins. Co. Address_____ City_____State_____Zip_____ Ins. Co Phone_____ Policy Holder_____D.O.B_____ Social Security No_____ Employer_____ Group No_____ID No._____	Payment is due at 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 $210 per 45 minute session. One hour evaluations or treatment sessions are thus prorated to $280. I will bill for appointments cancelled less than 24 hours in advance. If you have any questions concerning your bill or insurance, please discuss these with me.

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 being 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