New Patient Information

Today's Date:

Name	Age	Sex	D.O.B.	Educ.	Relation to Primary Patient	
Primary Patient					↓	
Other Household Members						

Primary Patient (If Child, enter parent info)		
Address:	City	Zip
SS#	Employer	Occupation
Phone #'s (where we have authorization to leave message for you)	Email (where we have authorization to email you)	
Spouse / Other (If applicable)		
SS#	Employer	Occupation
Phone #'s (where we have authorization to leave message for you or spouse)	Email (where we have authorization to email you or spouse)	

Referred by
Name: Physician __ Internet __ Insurance __ Counselor __ School __ Clergy __ Friend __ Other __
If Referred by Health Care Provider, do we have your authorization to contact them for coordination of care? Initial if Yes _____ No __

Significant Medical History (Current Medications / Medical Procedures)

Primary Care Physician:

Past or Current Mental Health / Substance Abuse Treatment

List any Issues you would like to address (or you may wait to discuss these with your therapist)

Insurance Information			
Name of Insurance Co	Address:	Phone	Authorization Number
Name of Primary Insured	SS#	DOB	Employer
Insured ID or Policy #	Group #		# Visits Authorized (if Applicable)

Authorization & Release. Please initial each blank unless it does not apply.
I certify that the above information is correct and assume responsibility for payment for services. I hereby consent to treatment by Deanna Kasper LPC __ for myself or child listed above, and understand that if I have any questions regarding benefits or risks of treatment that I am encouraged to discuss these with my therapist. _____ I authorize release of my medical records to my insurance, EAP, PPO or other 3rd party payers for the purpose of authorization of treatment and/or as required for purposes of billing authorized 3rd parties. ____.

_____ Date _____
Patient or Responsible Party Signature

HIPAA Acknowledgement of Receipt of Privacy Policies:
I acknowledge that __ Deanna Kasper LPC has provided me with the Notice of Privacy Practices by making it available as a paper copy by the federal government's HIPAA legislation. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

_____ Date _____
Patient or Responsible Party Signature