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Name ____Date______________

Phone___________________________________ Email___________________________________

Address____

City___________________________________State/Zip Code________________________________

May I contact you by phone? Yes____No____ If yes, at which number?____________________

If unavailable, may I leave a message? Yes____ No____

May I send text messages regarding appointments? Yes____ No____

May I contact you by email? Yes_____ No_____ May I contact by mail? Yes____No____

Please be advised, the use of email and text messages are not fully secure forms of communication

**Signature(s) agreeing to above preferences of contact____

____

Age_____ Date of Birth___/___/______

Employment Information (if applicable):

Name_____________________________ Length of Employment___________________________

Address____

City______________________________State/Zip Code_________________________________

Referred By:____

Do you have any current or past medical problems I should be aware of? Yes___No___

If yes, please describe____

Are you regularly taking medication? Yes___No___ If yes, please describe___________

____

Prescribing Physician Name____

Phone___________________________________

Have you received any past psychiatric or psychological services? Yes____No____

If yes, where______________________________When________________________

Name of provider(s)____

Are you experiencing any suicidal thoughts? Yes____No____

Do you or your family members have a history of any of the following?

(Check all that apply)   If yes, who?

	Alcohol/Substance Abuse	
	Depression	
	Suicide Attempt	
	Eating Disorder	
	Criminal Activity	

Information about presenting issue, symptoms or goals related to what brings you into therapy today:____
____
____
____

Please provide your identification card to provider or complete the following:

Name of Insurance Company____

Address and Phone Number (of Insurance Company)______________________________

____

Group Number______________________Policy Number_________________________

ID Number____

Place of Employment__________________________SS#________________________

If you are not the primary insured party on your policy/card, please complete the following:

Name of Insured_________________________ Insured's Date of Birth ______________

Gender_______ Place of Employment_________________________________

Insured's SS#____________________Relationship to Insured______________________

<u>Payment Information (to be filled out by client/patient)</u>:

Insurance Authorization

My signature below authorizes Healing Path Counseling, LLC, to bill my insurance carrier, if in network. I understand they require some clinical information, such as diagnoses. I instruct that payments be made to Healing Path Counseling, LLC, Dr. Brigid Zarbock. I am aware that I am responsible for co-payment and/ or fees not covered by insurance.

____

Name of Client/Insured (Print)

_______________________________ _________________________

Signature of Client/Insured Date

_______________________________ _________________________

Signature of Parent or Guardian Date

Cancellation Policy

I understand that should I, at any time during the course of my treatment, need to cancel, I will need to notify the office 48 hours in advance of the appointment time or be charged for $80 since the time has been reserved for me and without sufficient notice is unavailable to anyone else. Further, if I do not call before the appointment or if I do not show, I will be charged $100.

____
Name of Client/Insured (Print)

___________________________________ ______________________________
Signature of Client Date

___________________________________ ______________________________
Signature of Parent or Guardian Date

Payment Policy

I understand that although my insurance may pay a portion of the cost of the professional services received in this office, I am ultimately responsible for complete payment of charges

____
Name of Client/Insured (Print)

______________________________________ _______________________________
Responsible party please sign here Date

______________________________________ _______________________________
Responsible party please sign here Date