**INFORMATION SHEET**
**(Please Print)**

**PATIENT INFORMATION** **Date:** ______________

Name: ____________________________________

Address: ____________________________________

____________________________________

Home Phone: ____________________________
Permission to leave message: Yes No
Work Phone: ____________________________
Permission to leave message: Yes No

Birthdate: ____________________________________

Soc. Sec. #: ____________________________________

Emergency Contact: ____________________________
Phone #: ____________________________________
Relationship to Client: ____________________________

Employer: ____________________________________
How Long? ____________________________
Occupation: ____________________________________

Years of Education: ____________________________

Marital Status: ____________________________________

Ethnicity: ____________________________________

Optional:
Annual household income: _$______________
How many people are dependent on this income? ________

Referred to office by: ____________________________

**PRIMARY INSURANCE INFORMATION**

Policy Holders Name: ____________________________

Relationship to client: ____________________________

Work Phone: ____________________________________
Home Phone: ____________________________________

Birthdate: ____________________________________

Soc. Sec. #: ____________________________________

Insured's Employer: ______________________

Insurance Co: ____________________________

Address: ____________________________

____________________________

Plan Name:____________________________

Insured's ID #:____________________________

Policy Group #: ____________________________

**Authorization to Release Information**: I authorize the release of any medical or other information about me related to all claims to my insurance carrier/EAP provider and its agents in order to determine benefits or the benefits payable for related services.

___________________________ ________________
Signature Date

**Authorization to Pay Benefits to Provider**: I authorize payment of medical benefits be made either to me or on my behalf to Dr. Gadt-Johnson for any services furnished to me by this doctor. Where applicable, I also request payments of government benefits to the party who accepts assignment.

___________________________ ____________
Signature Date

Please initial next to each statement and sign at the bottom.

- I authorize use of this form for all of my insurance/EAP submissions and permit a copy of this form to be used in place of an original. ______
- I understand that I am responsible for the full amount of my bill for services provided (the exception being authorized EAP services and disability evaluations). _________
- I understand that there will be a $25 service charge on all returned checks. ________
- I understand that there is a 24-hour appointment cancellation policy that requires me to cancel my appointment 24 hours in advance to avoid being charged a $40 no-show fee. I further understand that insurance/EAP carriers will not pay for this no-show fee. _________
- I understand that any phone consultation exceeding 10-minutes will be billed at the same hourly rate as office visits. _________
- I have received a copy of and read the information in the PSYCHOTHERAPIST – PATIENT SERVICES AGREEMENT. I agree to abide by its terms during our professional relationship. ________
- I have received the Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information (HIPAA Notice of Privacy Practices) form. _________
- I am not aware of any reason why therapy/assessment services should not proceed. ________

The following item will be completed after consultation with my therapist.

The agreed upon charge is $______ for each visit. Paperwork or other requests will be a separate cost if not done during the allotted time. I understand that I am responsible for the full amount of this charge, which is due at the time of service. _________

_________________________ ______________
Signature Date