Amanda DePippo, LMHC, CAP

PATIENT INFORMATION

Name: _____
(Last) (First) (Middle Initial) (Nickname)
Mailing Address:_____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)
Home Phone:_____ Work Phone:_____ Ext. #:_____ Cell: _____
E-mail Address:_____
Social Security #: _____ Sex: ❒M ❒F Birth date:_____ Age: _____
Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed ❒Other _____

GUARANTOR INFORMATION ***(Person who is financially responsible)***

Name: _____ Birth date: _____
(Last) (First) (Middle Initial)
Mailing Address: _____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)
Relationship to Patient: ❒Spouse ❒Mother ❒Father ❒Sibling ❒Other (relationship)
Home Phone: _____ Cell Phone: _____ Soc. Sec. #: _____

INSURANCE INFORMATION

Complete the following ONLY if we are filing claims for you.

Primary Insurance Co. Name: _____ Phone: _____
Subscriber's Name: _____ Relationship to Pt: ❒Self ❒Spouse ❒Parent ❒Other _____
Employer: _____ Phone: _____
Birth date:_____ Member ID #: _____ Group ID #: _____
Social Security Number: _____

Secondary Insurance Co. Name: _____ Phone: _____
Subscriber's Name: _____ Relationship to Pt: ❒Self ❒Spouse ❒Parent ❒Other _____
Employer: _____ Phone: _____
Birth date:_____ Member ID #: _____ Group ID #: _____
Social Security Number: _____

CONSENTS TO RELEASE INFORMATION

I hereby consent for *Amanda DePippo, LMHC, CAP* to contact the following parties as noted below regarding my treatment, as deemed necessary. This consent shall remain in force during my treatment at *Amanda DePippo, LMHC, CAP* and for 90 days following my last visit unless expressly revoked by me in writing.

Name: _____ Phone #: _____
Address: _____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Name: _____ Phone #: _____
Address: _____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

_____ _____
Client Signature **Date**

(Please be sure to review page 2, and sign form at the bottom.)

ACKNOWLEDGEMENTS

By signing below, I acknowledge the following:

- I have been offered the "Notice of Privacy Policies."
- I have consented to treatment provided by *Amanda DePippo, LMHC, CAP*. I authorize the services deemed necessary or advisable to address my needs.
- I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, and obtaining payment for my care. I authorize *Amanda DePippo, LMHC, CAP* to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that *Amanda DePippo, LMHC, CAP* may release objective clinical information related to my diagnosis and treatment that may be requested by my insurance company (if applicable) or its designated agent.
- I authorize and request my insurance plan (if applicable) pay directly to *Amanda DePippo, LMHC, CAP* amount due for services rendered to the patient, myself, or others covered by the above insurance plan(s). I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered. I understand that this consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this consent will be null and void six months after the final payment has been received on this account. This consent is subject to state and federal confidentiality regulations.
- I agree to take full responsibility for the entire amount due for any and all services rendered. If the provider is contracted with my insurance company, I will be responsible only for the co-pay, co-insurance, deductible, and non-covered services as determined by the insurance plan. If I do not inform *Amanda DePippo, LMHC, CAP* in a timely manner of any changes to my insurance coverage, I understand that I may need to pay for services in full if payment is denied in part or in full by my insurance carrier. I further understand that I may not be able to schedule appointments if my account becomes delinquent and/or my account is turned over to collections.
- I understand that my patient records are the property of *Amanda DePippo, LMHC, CAP* and shall be treated as confidential; that *Amanda DePippo, LMHC, CAP* will conduct routine patient audits to insure quality record maintenance; that my records will not be released without my written consent or as provided by the laws of the State where I am receiving treatment. I understand that if I choose to have my records or treatment updates provided to a third party, I must request this in writing using *"Authorization for Use and Disclosure of Protected Health Information"* form or another acceptable form, with the exception of information I have agreed to release per this Acknowledgement.
- I acknowledge that if I need to cancel or reschedule an appointment I will provide a minimum of one business day's notice. Otherwise, I understand that I am subject to the full charge for the missed appointment and am responsible for payment in full.
- I acknowledge that *Amanda DePippo, LMHC, CAP* is not a 24/7 care facility and that I am responsible for seeking care at my nearest emergency center or through another provider of choice when *Amanda DePippo, LMHC, CAP* is not available.

I certify that all the information I have provided above is true and correct.

❒ *Please check the box if we have your permission to contact and thank the referral source for recommending our center.*

Patient Signature: _____ **Date:** _____

Guarantor's Signature *(if not patient)*: _____ **Date:** _____

Patient/Guardian Name *(please print)*: _____

PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF APPLICABLE

CHILD AND ADOLESCENT CONSENT FOR TREATMENT

I certify that I am the ❒father, ❒ mother, ❒ legal guardian and have legal custody of the above named patient. I, hereby, give my authorization and consent for the patient to receive outpatient assessment/treatment from _____ .

I understand it is the policy of *Amanda DePippo, LMHC, CAP* that the parent/guardian bringing the patient for treatment is responsible for payment at the time services are rendered. I will be responsible for payment of the patient's treatment regardless of any financial arrangement for payment of the patient's medical care, either oral or written, with the patient's other parent or responsible party. I understand that *Amanda DePippo, LMHC, CAP* assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements for the patient's medical care.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____**Date:** _____

TO BE COMPLETED ONLY BY STAFF

Provider: _____

Appt: _____

Staff Witness: _____

Comments: _____

_____