INITIAL INTAKE

PLEASE PRINT

DATE_____ THERAPIST _____Dr. Jann_____

PATIENT NAME _____ **DOB** _____ *Sex* **M** ____ **F** ____

ADDRESS (street) _____

(City/State/Zip) _____

TELEPHONE (H) _____(W)_____(C)_____

PATIENT SS# _____ EMAIL _____

PATIENT EMPLOYER/SCHOOL NAME _____ _____ EAP ___Yes __ No

PATIENT MARITAL STATUS: Single ____ Married ____ Widowed ____ Divorced _____

Emergency Contact Name _____ Phone: _____

Responsible Party Name_____ Relationship to patient_____

Address_____

TELEPHONE (H) _____(W)_____(C)_____

Responsible Party SS# _____D.O.B. _____

INSURANCE_____ EAP ___Yes __ No

POLICY HOLDER _____

POLICY HOLDER SS# _____ Policy Holder D.O.B. _____

POLICY I.D.# _____GROUP # _____

Relationship to patient _____ CO-PAY_____

PATIENT AGREES TO TREATMENT

SIGNATURE_____

OFFICE USE:

Diagnosis Code _____ Description_____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (Please Read Carefully)

HIPAA (Health Insurance Portability and Accountability Act) requires our office to obtain your permission to use or disclose your health information. We create paper and electronic medical records about your health and the services that we provide to you as our patient. We understand that your out-patient mental information is personal to you, and we are committed to protecting that information for you. Your signature on this consent gives our office permission to perform the following:

	Yes	No
Bill your insurance company	___	___
Communicate with your primary care physician	___	___
Communicate and disclose information to your insurance company	___	___
Contact you via phone to remind you of appointments	___	___
Communicate with anyone identifying themselves as a family member	___	___

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This consent authorizes us to use and disclose health information about you for treatment, payment, and health care operations. We have a Notice of Privacy Practices, which describes how we use and disclose protected health information about you and how you can access your protected health information. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain. You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. We are not required to agree to any requested restrictions. However, if we agree to a requested restriction, we are bound by that restriction. You have the right to revoke this consent, except to the extent that we have taken action in reliance on the consent. To revoke this consent, you must submit a written revocation to our administrative office at Ste 216, 6 Penns Trail, Newtown, PA 18940 and 301 Oxford Valley Road, Suite 301B, Yardley PA 19067.

CONSENT

I have read and understand the above Explanation of Rights and have been provided the opportunity to review our Notice of Privacy Practices prior to signing this consent. I authorize the use and disclosure

of health information about _____ (patient name) for treatment, payment, and health care operations in accord with the Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient's representative (patient representative be 18 or older) Date

_____ _____

Name of Patient Representative Relationship to Patient