New Client Form

Linda J. Hunt, RN, LPC

Personal Information

Name: _____ DOB: ___ / ___ / ___ Marital Status: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

May your therapist leave you a voicemail? Y / N Please indicate which phone(s): Home Cell Work Other:_____

May your therapist send you text messages to your cell phone? Y / N

May your therapist send you emails? Y / N

Occupation: _____ Employer: _____

Current Medications: _____

Allergies: _____

Primary Care Physician: _____ Phone: _____

Date of Last Visit: ___ / ___ / ___

Would you like for me to contact your primary care physician: Y / N

Insurance Information

Primary Insurance: _____

Policy Holder: _____

DOB: ___ / ___ / ___

Relationship to Insured: _____

Secondary Insurance: _____

Policy Holder: _____

DOB: ___ / ___ / ___

Relationship to Insured: _____

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Assignment of Benefits, Financial Policy, Waiver, and Confidentiality Statement

1) Payment must be made at the time services are rendered.
2) A cancellation fee of $125 will be charged for missed appointments unless a 24 hour notice is given.
3) Failed appointments are not covered by insurance.
4) Linda J. Hunt is authorized to release Protected Health Information (PHI), excluding psychotherapy notes, in order to carry out treatment, payment, and healthcare operations.
5) Payments of any benefits will be made directly to Linda J. Hunt.
6) If any insurance denies payment, the client is personally and fully responsible for the payment of the account.
7) Failure to pay will result in legal action. The client will be responsible for all collection expenses, attorney fees, and court costs that may be incurred in collection of payment.
8) Clients that request Linda J. Hunt to appear in court for testimony will be responsible for payment of time, travel, and attorney fees if legal representation is necessary.

My signature below indicates that I, _____, have read the Assignment of Benefits, Financial Policy, Waiver, and Confidentiality Statement. I understand the limits of confidentiality required by law. I consent to the use of diagnosis in billing insurance companies, and to the release of that information and other information necessary to complete billing for my therapy sessions. I understand my rights and responsibilities as a client and my therapist's, Linda J. Hunt's, responsibility to me.

Client Signature: _____ Date: ___ / ___ / ___