New Client Form

Linda J. Hunt, RN, LCMHC

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: ______________________________ Secondary Insurance: ______________________________

Policy Holder: __________________________________ Policy Holder: __________________________________

DOB: ___ / ___ / ___ DOB: ___ / ___ / ___

Relationship to Insured: __________________________ 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: ___ / ___ / ___