GOODMAN
PSYCHOLOGIST ASSOCIATES

Client Information

Patient Name: _____ Date of Birth: _____

Street Address: _____ Gender Identity: _____

City: _____ State: _____ Zip: _____ Marital Status: _____

Client's Email address: _____ First Language: _____

Client's Home phone: _____ May we leave a message? ☐ Y ☐ N

Client's Cell Phone: _____ May we leave a message? ☐ Y ☐ N

Would you like a text reminder sent to this phone? ☐ Y ☐ N

How did you hear about our practice?

☐ PCP referral ☐ Friend ☐ Family ☐ Insurance ☐ School Professional ☐ Internet ☐ Social Media

Parent or Guardian Information *(If applicable)*

Marital status of the client's parents: ☐ Married ☐ Divorced ☐ Separated

Divorced or Separated parents must read and sign our consent to treat a minor form.

Primary Email contact: ☐ Mother ☐ Father ☐ Both

Appointment Text Reminder: ☐ Mother ☐ Father (Only one can be checked)

Mother's Name: _____ Father's Name: _____

Cell Phone#_____ Cell Phone#_____

Mother's Email: _____ Father's Email: _____

Primary Insurance Information

Subscriber's name: _____ Date of Birth: _____

Street Address: _____ Gender Identity: _____

City: _____ State: _____ Zip: _____ Phone number: _____

Relationship to the subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

No need to complete the following information if you have provided a copy of the front and back of your insurance card.

Insurance Company: _____ Phone number: _____

Claims Address: _____ Member ID#_____

City: _____ State: _____ Zip: _____ Group # _____

Secondary Insurance Information

Subscriber's name: _____ Date of Birth: _____

Street Address: _____ Gender Identity: _____

City: _____ State: _____ Zip: _____ Phone number: _____

Relationship to the subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

No need to complete the following information if you have provided a copy of the front and back of your insurance card.

Insurance Company: _____ Phone number: _____

Claims Address: _____ Member ID#_____

City: _____ State: _____ Zip: _____ Group # _____

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Primary Care Physician Information

Communication between Behavioral Health providers and your Primary care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This section will allow your therapist to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis and treatment plan.

My Primary Care Physician is _____

Group Name:_____

Phone: _____

Address: _____

Fax: _____

☐ I agree to release any applicable mental health/substance abuse information to my PCP

☐ I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services and I direct you NOT to so notify him/her.

☐ I do not have a PCP and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

Patient Rights:

- You can end this authorization at any time by contacting: 630-377-3535
- Ending authorization does not include information that has already been used to disclosed
- You do not have to agree and will not be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits
- You have a right to copy of this signed authorization

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FOR YOUR REVIEW AND CONSENT

I do hereby seek and consent to take part in the treatment at Goodman Psychologist Associates. I understand that developing a treatment plan with my clinician and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to take an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this clinician.

I am aware that I may stop my treatment at any time and that I am still responsible for paying for services already rendered. I understand that the financial, including insurance aspect of the counseling process is my complete responsibility.

I understand that I must call to cancel an appointment at least 24 hours before the time of my appointment or I will be charged the missed/late cancelation fee, since this time had been reserved by me and without sufficient notice is unavailable to anyone else. I understand that Goodman Psychologist Associates has the right to charge my designated credit card.

I understand that if I do not pay my bill within 30 days of the statement date or make financial arrangements, Goodman Psychologist Associates has the right to charge my designated charge card the full amount. I further understand that if I have not made a payment on my account within 30 days, Goodman Psychologist Associates has the right to turn my account over to collections without my advance notice.

I acknowledge that I have received, have read (or have had read to me), and understand the Practice Agreement and Policies. I further acknowledge that I have had the opportunity to ask questions about the agreement with my clinician or the business office.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: (1) Conduct, plan, and direct my treatment; (2) Obtain payment from third-party payers.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive is not made, the clinician may stop treatment.

I understand and agree that Goodman Psychologist Associates, and its billing consultant may provide to me, by electronic means, information regarding my account services. Communication may include your name and other information regarding billing and payments, making or scheduling appointments, and updating demographics. I acknowledge that by giving my consent I demonstrate that I can access the information that Goodman Psychologist Associates, provides to me electronically. I understand that by choosing to communicate with Goodman Psychologist Associates, electronically that I assume all risks associated with this chosen method of communication. I may also withdraw my consent in writing at any time.

By signing below, I agree that I have read and agree to the above statements.

Client Signature: _____ Date: _____
(12 years of age or older)

Parent/Guardian Signature: _____ Date: _____

Second Client Signature: _____ Date: _____
(If couples)