<u>VERY IMPORTANT:</u> If you are seeing another mental health provider (psychiatrist, counselor, etc.) and you are on a managed care plan, or you have had an evaluation done elsewhere, it is essential that we have that information to know how many visits and how often to request authorization for further sessions. Please list any other mental health care providers you have seen in the past 3 years below.

_____
_____
_____
_____

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF <u>ANY INFORMATION</u> TO **<u>ALL</u>** OF MY INSURANCE COMPANY(IES) FOR CLAIMS SUBMITTED ON BEHALF OF ME AND/OR MY DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE BELOW AUTHORIZES DR. KRACKE AND ASSOSICATES, P.A. TO SUBMIT CLAIM(S) FOR SERVICES RENDERED WITHOUT OBTAINING MY SIGNATURE ON ANY AND ALL CLAIM(S) SUBMITTED. <u>ANY FAILURE TO DISCLOSE ADDITIONAL INSURANCE WILL RESULT IN OUR BILLING YOU FOR THE CHARGES.</u>

I UNDERSTAND I AM THE PARTY RESPONSIBLE FOR ALL CHARGES FOR SERVICES - REGARDLESS OF INSURANCE COVERAGE AND AGREE TO ASSIGN ALL BENEFITS TO DR. KRACKE AND ASSOCIATES, P.A. AND/OR PAY FOR SERVICES FOR ME AND/OR ANY OF MY DEPENDENTS OR PERSONS LISTED AS PATIENT, REGARDLESS OF RELSTIONSHIP TO ME.

X _____ _____
Signature for Primary Insurance *Date*

X _____ _____
Signature for Secondary Insurance *Date*

Please bring your photo ID and insurance cards and give to receptionist or therapist for copying. Thank-you!

Dr. Kracke & Associates, P.A.

NEW CLIENT INFORMATION SHEET (ADULT)

Therapist: _____ Appointment Date: _____ Appointment Time: _____ AM/PM

Patient Information

Patient Name: _____ Date of Birth: _____ Age: _____
Social Security Number: _____-_____-_____ Marital Status: _____ Gender: _____
Mailing Address: _____
Street Address: _____
Email: _____@_____ May we contact you by email? ____ (Initial _____)
Cell Phone: _____ (Detailed message? ____) Home Phone: _____ (Detailed message? ____)
Employer/ School: _____ Work Phone: _____ MSG OK ____
Spouse Name: _____ OK to contact? ____ Phone # _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Primary Care Physician: _____ Date of last visit: _____
PCP Address: _____ Phone: _____ Fax: _____
Do we have your permission to contact the physician listed above? ____ (Initial _____)
Please list ALL allergies: _____
Please provide all current Medications and Dosages (use separate sheet if needed): _____
_____
_____

May we text you at the cell phone number provided? ____ (Initial _____)

Primary Insurance Policy Holder/Responsible Party

Full Name: _____ Date of Birth: _____ Relation to patient: _____
Social Security Number: _____-_____-_____ Email: _____@_____
Mailing Address: _____
Street Address: _____
Cell Phone: _____ (Detailed message? ____) Home Phone: _____ (Detailed message? ____)
Employer: _____ Address: _____ Phone: _____
Name of Primary Insurance: _____
Subscriber ID#: _____ Group#: _____ Effective Date: _____
Insurance Address: _____ Phone#: _____
Does the patient reside with the policy holder? ____ If not, where? _____

Secondary Insurance Policy Holder/Responsible Party

Full Name: _____ Date of Birth: _____ Relation to patient: _____
Social Security Number: _____-_____-_____ Email: _____@_____
Mailing Address: _____
Street Address: _____
Cell Phone: _____ (Detailed message? ____) Home Phone: _____ (Detailed message? ____)
Employer: _____ Address: _____ Phone: _____
Name of Secondary Insurance: _____
Subscriber ID#: _____ Group#: _____ Effective Date: _____
Insurance Address: _____ Phone#: _____
Please list ALL other existing insurance covering patient: _____