Robyn Macfarlane, MA, LPC, PLLC
10720 Carmel Commons Blvd., Suite 330
Charlotte, NC 28226
(704) 612-4141

CLIENT INFORMATION FORM

Today's Date: _____

Name: _____

DOB: _____/_____/_____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Is it okay to leave a message?_____

Employer: _____

E-Mail Address_____

Is it okay to email you appointment reminders? Yes No

Emergency Contact

Name: _____

Address: _____

Phone Number: _____

INSURANCE AUTHORIZATION OF BENEFITS

Insurance Company for Mental Health Benefits: *(very important-can be a different company)*

Name of Insurance Company: _____

Address of Insurance Company: _____

Phone Number of Insurance Company: _____

Subscriber Name: _____Subscriber DOB: _____

Relationship to Subscriber: Self Spouse Parent Guardian Other_____

Policy Number: _____Group ID #: _____

Effective Date: _____ Subscriber's Employer: _____

(If applicable) Name of secondary insurance: _____

Please attach copy of insurance card (front & back)

I authorize Robyn Macfarlane to release any necessary information acquired in the course of my treatment to process insurance claims and to submit claims for payment of medical benefits to Robyn Macfarlane, MA, LPC, PLLC. Robyn Macfarlane will file my claim for me, and re-file if necessary, but will not assume responsibility for collecting on my insurance claim or negotiating settlement on a disputed claim. **If my insurance does not pay my claim or I choose not to use insurance, I understand that I am responsible to pay the hourly session rate of $120.00.**

Signature: _____ Date _____

CANCELLATION/MISSED APPOINTMENT POLICY

In scheduling an appointment, you are reserving that time slot for your therapy. If you are unable to attend your session you must provide a 24 business hours notice. Missed or cancelled appointments will incur a $75 fee unless 24 business hours notice is given. Insurance companies will not pay for missed appointments or late cancellations.

Your signature below represents your understanding and agreement to this policy.

_____ _____

Signature Date

TREATMENT INFORMATION

Please describe briefly the problem(s) you are experiencing and what has led you to seek counseling:

_____

_____

_____

_____

Please list medications (if applicable): _____

History of any mental health medications in the past? Yes No

If yes, please list medications_____

History of counseling/treatment in past? Yes No