Amy Davenport Dakin, LCMHC, LCPC, NCC
53 Church St. #4 Kingston, NH 03848

Client Information—Minor

***Please note!! The parent bringing a minor child to the appointment is the responsible party*

Today's Date: _____

Client's Full Name: _____

_____

Address: _____ City: _____

State: _____ Zip: _____

Phone: _____ Length at Present Address: _____

****

I will be paying today by check or cash (please circle one).

Responsible Party**: _____

Phone: _____ _____

Address: _____ City: _____

State: _____ Zip: _____

SS #: _____ Employer: _____

_____ Phone: _____

Spouse of responsible party: _____ _____

SS#: _____ Employer: _____

_____ Phone: _____

****

Person to Contact in Case of Emergency: _____

Home Phone: _____ Work Phone: _____

Client's Physician: _____ Date of Last Exam: _____

Reason for Referral: _____ Referred By: _____

Previous Therapy?: _____ With Whom?: _____

Insurance Information (if applicable)

Company: _____

Address: _____

_____

Phone: _____

ID #: _____

Group: _____

Insured: _____

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Authorization to release information and assignment of insurance benefits.

I hereby authorize Practitioner to:

1) Furnish my insurance company with any/all information requested concerning my present claim(s).

2) Bill my insurance company and accept payment from that company on my behalf for all services from time to time relating to my care.

I acknowledge that I am responsible for all charges not covered by my insurance. I agree that if costs or fees are incurred in connection with the collection of this account, I will pay all such costs and fees, including, but not limited to, collection costs, attorney's fees, and all court costs. I understand that failure to resolve any outstanding balance may result in any account being referred to a collection agency if it remains delinquent without a response from me.

Notice of Information Practices

Notice: I keep a record of the services I provide you. You may ask to see and copy that record. You may also ask to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it from our office staff. The fees for copying records, searching for records, or editing records are as follows:

Copying:	
Searching:	$15 per search
Editing (by the therapist personally when required by statute)	Basic office visit charge

All copies will be released only upon receipt of payment.

_____ _____

Responsible Party's Signature Date