Client Information

Date_____Social Security #_____

Name _____
Last First Middle other/maiden

Addres_____
Street City SD Postal Code

Date of Birth _____/_____/_____Age _____ Male___Female ___ Race_____

Best Contact Phone ( ) _____ Is it ok to leave a message? _____

Would you like to receive text reminders? _____ Cell Number_____

Reason for today's visit_____

Health Information
Referral Source _____Is Spirituality important to you? _____

Have you had previous mental health treatment?_____If yes, with whom and when?_____
_____

Hospitalizations for Mental Health concerns _____ If yes, where and when_____
_____

Do you smoke?_____ Packs per day? _____ For how long? _____
Do you use Alcoholic beverages? _____ If yes, how often? _____

Please list medications you are currently taking:

Drug _____ Dosage _____ Schedule_____

Drug _____ Dosage _____ Schedule_____

Drug _____ Dosage _____ Schedule_____

Drug _____ Dosage _____ Schedule_____

Prescribing physician_____

Physician Authorization
If your physician referred you, it may be useful for your therapist to confer with him/her regarding your diagnosis and treatment.

I give my permission for my therapist, Ronda Maass, to release records and /or information about my treatment to my personal physician for the purpose of treatment planning and coordination of services for my health care needs. I may withdraw this concert at any time in writing or verbally, by advising my therapist.

_____ *Yes, I AUTHORIZE this release.* _____ *NO, I DO NOT.*

Family

N**ame - age - relationship of family members or significant persons living in the home**

_____

_____

Educational History of Client
School Attending or Attended_____ Years complete_____
University/Tech School _____ Years complete
_____

Employer _____

Spouse - Parent (**i**f the client is a minor)_

Name _____Custody held by _____

Address (if different from your child) _____

INSURANCE INFORMATION

Will you be using insurance?_____ EAP?_____ Private Pay?_____

Please be prepared to have your insurance card(s) scanned. Copays are due at the time of the session.

Person responsible for services unpaid by insurance
Bill to_____

Address if different from client_____

Insurance Policy Holder_____ Relationship to Client _____
(Name as it appears on Insurance Card)

DOB _____ SS#_____ Policy Holder's Employer_____

Primary Insurance Company _____
Does it cover mental healthcare? _____CoPay Amount?_____
What is your deductible? _____Is your deductible satisfied? _____

Secondary Insurance _____
Policy Holder_____Relationship toClient_____
Policy Holder's Employer_____DOB_____SS# _____

I authorize Ronda Maass to release necessary information to insurance carriers concerning my diagnosis and treatment in order to process claims. In addition, I hereby authorize direct payment of medical benefits to Ronda Maass for services rendered. I realize and agree to pay the portion that is not covered by insurance including but not limited to co-insurance, deductible and co-pay.

Signed _____Date _____