**Initial Contact Form**

**Patient Full Name**:

**Patient Date of Birth**: **Patient Sex**:

**Patient Full Address**:

(including zip code)

**Best Phone Number**:

**Best Email Address**:

If patient is a minor,

**Guardian’s Full Name**:

**Guardian’s Date of Birth**: **Relationship to Patient**:

**Insurance Company**:

(we are currently not accepting

Medicaid, Medicare or Tricare)

**Are you seeking services in order [ ] YES [ ] NO**

**to resolve a custody situation**?

**What type of services are you seeking**?

 [ ] Testing (Adult ADHD)

 [ ] Psychotherapy (counseling)

 [ ] Psychiatric services (including assessment and medication management)

**Any particular provider you wish to see?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us**?

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In addition to filling out the above information, please send us the following:

* a photo copy of your **ID (driver’s license)**
* a photo copy of your **insurance card (front and back).**

You can upload the copies directly to the website at [www.akserenity.org](http://www.akserenity.org) or email them to clinic@akserenity.org. Once this is done, our office will call you to schedule an initial appointment.

Please call us at 907 223 3879 if you have any questions or need assistance.