Today's Date: _____

CLIENT INFORMATION:

Patient's Full Name (Last | First | Middle)	Preferred Name:	DOB: Age:	Gender: ☐F ☐M	SSN:

Marital Status: Single ☐ Married ☐ Other ☐ _____
Spouse's Name | Phone:

Employed Y☐ N ☐ Employer:_____
Student: Y☐ N ☐ Grade:____ School:_____

Home or Physical Address *(Street, City, State, Zip):*

Mailing Address (St,City,State,Zip): *(if different from home address)*

Contact Information and Appointment Reminder: (*Please provide ALL contact numbers and PICK ONE REMINDER option)*

Whose Phone:_____ (relationship to client) _____
Primary Phone: _____ Text:☐ Call:☐
Primary Email:

Whose Phone_____ (relationship to client)_____
Secondary Phone_____ Text:☐ Call:☐
Secondary Email:

Emergency Contact *(Name/Phone/Relationship):*

Who referred you to our office *(Name/Phone/Address):*

REASON FOR YOUR VISIT:

When did current symptoms appear?_____ First date of similar illness?_____
Condition related to employment? ☐Yes (Worker's compensation) ☐No (Another type of insurance)
Condition related to an auto accident? ☐Yes (Auto liability or collision) ☐No (Another type of insurance)
If yes, in what State did accident occur? _____ Condition related to any accident? ☐Yes ☐No

RESPONSIBLE PARTIES: [Pls put the information of the person or parties responsible for your treatment and payment of services]

Name:_____
Birthdate:_____ SSN:_____
Contact Number/s:_____
Mailing Address:_____
City/State/Zip:_____
Relationship to Client:_____
Employed Y☐ N ☐ Employer:_____
Email: _____

Name:_____
Birthdate:_____ SSN:_____
Contact Number/s:_____
Mailing Address:_____
City/State/Zip:_____
Relationship to client:_____
Employed Y☐ N ☐ Employer:_____
Email: _____

Note: *For parent/s bringing a minor child: The parent who brings the child in for the appointment is responsible for the payment of copay, co-insurance, deductible or any out-of-pocket costs not payable by insurance.. Payment is DUE at the time service is rendered.*

CUSTODY INFORMATION: **(*If client is a minor, choose one or explain further):***

☐Child lives together with BOTH parents and the court has not been involved in custody rulings or proceedings:
☐Child's parents have JOINT legal custody. The other parent's: Name /Address/ Phone is:_____
☐Responsible party has SOLE custody of the child and child lives with responsible party.
☐Legal Guardian is _____
☐Child resides with_____

INSURANCE INFORMATION: ☐Check this box if PRIVATE PAY and please provide alternative payment arrangement (*check one below):*

☐Check ☐Cash ☐Credit Card (*Please fill out the credit card authorization form at the front desk)* ☐Others *(please specify):*_____

FIRST INSURANCE:
Insurance Plan Name:_____
Subscriber ID#:_____
Group#:_____
Insurance Phone:_____
Claims Address:_____
Policy Holder:_____
Birthdate:_____
SSN:_____
Mailing Address:_____
City/State/Zip:_____
Phone:_____
Employer:_____
Relationship to Client:_____

SECOND INSURANCE:
Insurance Plan Name:_____
Subscriber ID#:_____ _____
Group#:_____
Insurance Phone:_____
Claims Address:_____
Policy Holder:_____
Birthdate:_____
SSN:_____
Mailing Address:_____
City/State/Zip:_____
Phone:_____
Employer:_____
Relationship to Client:_____

THIRD INSURANCE:
Insurance Plan Name:_____
Subscriber ID#:_____
Group#:_____
Insurance Phone:_____
Claims Address:_____
Policy Holder:_____
Birthdate:_____
SSN:_____
Mailing Address:_____
City/State/Zip:_____
Phone:_____
Employer:_____
Relationship to Client:_____

Disclaimer: *Insurance represents a contract between the insurance company and the family. It is the responsibility of the client or his/her family to know their benefits and limits of coverage prior to the appointment. Failure to learn these limits yourself does not relieve you from financial responsibility. If your insurance company requires you to get authorization from them before seeing a therapist and you do not do so, and as a result claims are denied, you are responsible for payment in full for the service/s rendered. If you request, and as a courtesy, we will call and obtain benefits information and or authorization from your insurance company. We are not financially responsible for incorrect benefits information given to our office. The final responsibility for payment is yours for any fees, or portion of fees not covered or not reimbursed by your insurance.*

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS:

I authorize the release of any information by my Psychotherapist and/or his/her agents necessary to process insurance claims and verify the availability of insurance benefits. I also authorize my Psychotherapist and/or his/her agents to apply for benefits on my behalf for covered services rendered by her/him. I authorize payment be made directly to her/her. I understand that I am financially responsible to her/him for charges not covered by my insurance or this assignment. I permit a copy of this authorization to be used in place of original. This authorization may be revoked by me at any time in writing.

Date:_____ Print Name:_____ Signature:_____

2500 Boardwalk St, Suite 210
Norman, OK 73069-6664
Email: positiveoutcomesok@gmail.com
Phone: (405) 857-8357
Fax#: (405) 857-1678

Client Full Name (Last, First, Middle Initial)	*Date of Birth*	*Phone#*	*SSN#:*
Mailing Address:			
If Client is a minor child: Please add responsible party or legal Guardian's information below: *Parent or Legal Guardian Name*	*Phone#*	*Email*:	

SIGNATURE PAGE

Your initials and signature below indicate that you have read, understood and agree to the terms and conditions stipulated on the policies and rules for service agreements for Positive Outcomes Therapeutic Services, LLC. You further acknowledge that you have received copies of the said forms.

ACKNOWLEDGMENT OF UNDERSTANDING: (Client must add initials on each form)

_____Client and Provider Service Agreement - I read, understand and agree to its terms and conditions.

_____Covid-19 Informed Consent for in-person visit- I read, understand and agree to its terms and conditions.

_____ Authorization for Electronic Communication- I read, understand and agree to its terms and conditions.

_____ Credit Card Authorization and Agreement Form- I read, understand and agree to its terms and conditions.

_____ Office Safety Precautions in Effect during Pandemic- I read, understand and agree to its terms and conditions.

_____Telehealth Consent Forms- I read, understand and agree to its terms and conditions.

Item 1: (Please complete if client is over 14 years of Age)

_____ _____ _____
Printed Client Name | Signature of Client | Date

Item 2: (Please complete this if <u>Client is a minor</u>)

By signing this document, I am certifying that I am legally authorized to consent to psychological treatment for the above-named minor client and agree to the above-mentioned terms of Agreement.

_____ _____ _____
Printed Name of Guardian Or Authorized Representative | Signature of Guardian or Authorized Representative | Date | Relationship to Child Client