Client Information Sheet

Client Name			
Address	City	State	Zip Code
Phone Number	Other Number		
Is it OK to contact you at the numbers above?	Yes / No		
Gender	Date of Birth	Age	Marital Status
Employer or School	If Client is Child, Name of Legal Guardian		
Highest Level of Education	Religious Preference		
Major Medical Conditions	Current Medications		
Referred By	Emergency Contact Name and Number		

CONSENT TO TREATMENT

I, ____, consent to treatment for therapy/

counseling for ( )myself or ( )minor ____ by
(name of Minor Child, if applicable)
Sara Pattavina Moulton, LCSW, LIMHP, granting her to provide treatments necessary for my condition that are generally used in this and similar settings

____ ___________________________
Signature of client or responsible party **Date**

CANCELATION POLICY
I consider appointments scheduled with my clients of the highest importance. In this regard, I request a minimum of 24 hours notice for all cancellations.
Your appointment time is held especially for you. Cancelling a scheduled appointment outside of the 24-hour timeframe results in waiting client missing the opportunity to be seen in a timely manner. **Any cancelation made less than 24-hours in advance will result in a $100 cancellation penalty.**

____ ___________________________
Signature of client or responsible party **Date**

Insurance Information

Name of Policyholder	How are you related to the Policy Holder?

If you are NOT the policyholder, please provide: Address (if different than yours)	Birthdate of Policyholder

To the extent necessary to determine liability for payment and to obtain reimbursement, **I authorize disclosure of the necessary client records**. If my insurance company requests information, I understand my therapist will notify me.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, Private Insurance and other health plans to be paid to Sara Pattavina Moulton, LIMHP, P.C.

The assignment of benefits will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

I understand that I am financially responsible for all charges whether or not paid by said insurance and I also understand that Sara Pattavina Moulton, LIMHP, P.C. is not responsible for my insurance company's decision about payment, I hereby authorize said assignee to release all information necessary to secure the payment.

I have read the above statement and agree to their terms.

____ ____________________

Signature of financially responsible party Date

Financial Policy

Thank you for choosing me as your mental health care provider. Please understand payment of your bill is considered part of your treatment. The following outlines some important information about your bill. If you have any questions about this policy or issues relating to insurance please speak with me at any time.

1. If your insurance deductible has not been met, you will need to pay in full at each visit
2. You may need to pay a co-pay at the time of each visit
3. Your account must remain in good standing (less than 30 days past-due) in order to continue receiving services at this office.

____ ____________________

Signature of financially responsible party Date

Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name:____

DOB: ____

SSN:____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Sara Pattavina Moulton, LIMHP, PC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Sara Pattavina Moulton, LCSW, LIMHP at 2808 S 80th Ave, Suite 130, Omaha NE 68124.

____

Signature of Patient/Client **Date**

____

Signature or Parent, Guardian or Personal Representative * **Date**

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* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

____

Signature of Staff Member **Date**

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