Expressive HeARTs THERAPY

410-449-0025

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Easton, MD 21601

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support@expressiveheartstherapy.org

NEW PATIENT INFORMATION

Date:

First: Middle: Last: Maiden:

Nickname: Social Security #: DOB: Age:

Mailing address:

Phone #: Text? ☐ Yes ☐ No

Email address: Email reminder? ☐ Yes ☐ No

Marital Status:

List all household Members:

Name: DOB: Relationship:

Name: DOB: Relationship:

Name: DOB: Relationship:

Name: DOB: Relationship:

Name: DOB: Relationship:

Person to contact in case of an emergency:

Name and address of Primary Care Physician:

Patient's School or Employer/Occupation/Phone number:

Name, address, and Phone number for person responsible for payment:

HAVE YOU EVER HAD MENTAL HEALTH TREATMENT PRIOR TO TODAY?

Primary Insurance information

Insurance Carrier: ID#: Group#:

Insured's Name:

Insured's Address:

Insured's DOB:

Insured's Employer:

Insured's Social Security Number:

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliant resolution. I authorize payment directly to this physician practice for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed:

_____

Date:

Office Use Only: (general comments)