MaryAnn Mattingly, MS NCC CCMHC LPC

Licensed Professional Counselor
Certified Clinical Mental Health Counselor
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907 522 2010

Patient Information Sheet

Patient First Name
_____

Last Name
_____

Address
_____

_____

_____

Email _____

May we send invoices or other communications by email? Y___ N___

Home phone _____

Work _____Fax_____

Cell _____

_____

Age____ Date of Birth _____

Marital Status_____

Employer/School _____

Position/Grade_____

Primary Care Physician_____

How did you hear about me or who referred you?_____

INSURANCE INFORMATION:

Primary Insurance (*We file primary insurance only*):

Company _____ ID # _____Group #_____

Sponsor's Social Security # (TRICARE ONLY): _____

Authorization #_____

Where do we send claims?

_____

_____

Who is the insured? _____

Insured's birth date? _____ Marital status of the insured_____

What is the relationship between the insured and the patient? _____

Who is the insured's employer? _____

Responsible Party's name and address if patient is a minor:

_____

_____

Parents' names (for minors): _____

AUTHORIZATION FOR TREATMENT:

I hereby authorize Mary Ann Mattingly MS, LPC to render any necessary therapeutic treatment or to make an appropriate referral. I also agree to pay all fees at the time of the appointment unless other arrangements have been made**. I agree to pay the full fees by check, cash or credit card, at the time of service, unless other arrangements have been made with Ms. Mattingly. I understand that Ms. Mattingly's office files *primary* insurance claims only, and are *not* able to file secondary claims. I understand that, regardless of whether my insurance pays Ms. Mattingly for her services, I am responsible for the payment of my account. I also understand that if I do not cancel a scheduled appointment *within 24 hours* of the scheduled time, I will be responsible for the *full* fees for that session. (As another alternative, I'm glad to hold a phone, or Skype session with you if you aren't able to make it in to the office.) The 24 hour cancellation policy is to allow another client the opportunity to have an appointment. I acknowledge receipt of the Fee Schedule, and Disclosure, and HIPAA Statement with the effective date 07-01-2013.** I will notify Ms. Mattingly of any changes in the patient or insurance information. The treatment program may be discussed with other professionals, and, if that occurs, the client's confidentiality will be maintained. The name and identity of the client will be disclosed only in compliance with the Statues and Regulations of the Board of Professional Counselors. I agree that my claims can be filed electronically to my insurance company including Tricare.

You have the right to treatment confidentiality. Information may not be revealed to anyone without written permission from you except when disclosure is required by law, as in the following circumstances: suspicion of child abuse, neglect, or abuse of a senior citizen; suspicion that the client presents a danger by having a plan to hurt himself or someone else; when disclosure may be required pursuant to legal proceeding; and where your insurance company requires information such as diagnosis, treatment plan, etc. to process claims. Individuals may choose to contact Ms. Mattingly via email, fax or cell phone. In doing so, they agree to the understanding that **cell phone, email, and fax communication are not guaranteed confidential methods of communication and when they converse by cell phone, email, or fax, they are, by choice, relinquishing their rights of confidentiality.**

Emergency procedures: for emergencies call 911, go to the emergency room or call the crisis line at 563-3200

Signature of patient _____ Date_____

Signature of responsible party if patient is a minor

_____Date_____

FAMILY INFORMATION:

PLEASE LIST *IMMEDIATE* FAMILY MEMBERS WHO LIVE WITH YOU OR OUTSIDE THE HOME, PLACING AN **X** BESIDE THOSE THAT LIVE WITH YOU:

X	NAME	BIRTH DATE /AGE	FAMILY RELATIONSHIP	OCCUPATION
__	_____	_____/___	_____	_____
__	_____	_____/___	_____	_____
__	_____	_____/___	_____	_____
__	_____	_____/___	_____	_____
__	_____	_____	_____	_____
__	_____	_____	_____	_____

OTHER PEOPLE RESIDING WITH THE FAMILY AND THEIR RELATIONSHIP TO THE FAMILY:

_____

HAVE YOU EVER BEEN IN THERAPY BEFORE?

Therapist:_____

Reason:_____

When:_____

MEDICAL INFORMATION:

Doctor's name: _____

Date of last physical exam:_____