Cedar Rapids Counseling & Psychotherapy Group, LLP

www.crcounseling.net

4403 1st Ave. S.E. – Ste. 309 *(mailing address)*
4403 1st Ave. S.E. – Ste. 313 *(Alexandria's office)*
Cedar Rapids, IA 52402-3221

319-362-0632 ext.3 (*Alexandria's extension)*
319-362-5206 *(fax)*

Please complete both pages and bring to your first session with Alexandria

A. CLIENT INFORMATION:

Code: _____
(please leave blank -therapist use only)

Today's Date: _____ **How/where did you get Alexandria's name:** _____

Client Name: _____
Last **First** **Middle I.** **Preferred Name**

Address: _____
Street/PO Box **City** **State** **Zip Code**

Client Date of Birth: _____ **Age:** _____ **Employer:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

To contact you by phone, please check which of the following would be acceptable:

___ Call home **___Call work** **___ Call cell phone**
___ Leave message on machine **___ Leave message on v-mail** **___ Leave message on v-mail**

B. INSURANCE INFORMATION: If you are covered by one insurance policy, complete part (1) below. If you are covered by two insurance policies, complete parts (1) and (2) below.

(1) Name of PRIMARY Insurance Company:_____

Subscriber Name: _____ **DOB:** _____ **Employer:** _____

Policy/ID Number: _____ ***(on insurance card)*** **Group Number:** _____ ***(on insurance card)***

Subscriber Address: (*if subscriber lives at different address from client or parent responsible for billing, please complete)*

_____
Street **City** **State** **Zip Code**

(2) Name of SECONDARY Insurance Company:_____

Subscriber Name: _____ **DOB:** _____ **Employer:** _____

Policy/ID Number: _____ ***(on insurance card)*** **Group Number:** _____***(on insurance card)***

Subscriber Address: (*if subscriber lives at a different address from client or parent responsible for billing, please complete)*

_____
Street **City** **State** **Zip Code**

C. SPOUSE/SIGNIFICANT OTHER

Name: _____ Phone(s): _____

D. EMERGENCY INFORMATION:

In the event of an emergency, who should be contacted? _____

Relationship to client: _____ Phone(s): _____

Primary Physician: _____ Psychiatrist: _____
Name **Name *(if applicable)***

E. IF CLIENT IS UNDER AGE 18 OR IN COLLEGE:

Mother's Name: _____ Phone(s): _____
Father's Name: _____ Phone(s): _____

Person responsible to pay for services: _____ Relationship to child:_____

Responsible Person's Address: (*if the responsible person lives at a different address from the client, please complete below)*

_____
Street City State Zip Code

GENERAL CONSENT ***(Please place a checkmark next to Option A or Option B)***

___ A. By signing this form, I am stating that the information I have provided is accurate. I also authorize Alexandria and her staff to release protected health information from my clinical record to any of the following entities as applicable for the purposes of certification of psychotherapy services and/or billing for payment of those services: (1) EAP program, (2) a county funding organization, (3) my health insurance company, and/or its (4) designated managed care company. I understand that this authorization continues indefinitely unless I revoke it in writing. However, if I revoke this authorization, I understand that any of the above entities retains the right to information in my clinical record prior to the revocation date.

___ B. By signing this form, I am stating that the information I have provided is accurate. I *do not wish* to have an insurance company or other third party pay for the psychological services provided to me or to the person designated as the "client" on the front of this form. I agree to be responsible for payment of all services provided.

_____ _____
Client/Parent/Legal Guardian **Date**