CLIENT INFORMATION SHEET

Trish Brown, M.A.

Date: _____

Name: _____ Date of Birth: _____/_____/_____

Street Address: _____

Mailing Address (if different): _____

City: _____State: _____ Zip: _____

SS#: _____ Marital Status: _____ Male: _____ Female: ____

Home Phone: _____ Work Phone: _____Other Phone: _____

Which is the best number to contact you if needed? : Home: _____ Work: _____ Other: ____

Emergency Contact: _____

Referred by:_____

Employed by: _____

Employer Address: _____

Employer Phone #: _____

Insurance Information:

Primary Insurance Company: _____

ID#: _____Policy #: _____Group #: _____

If different from above:

Insured's Name: _____ *SS#:* _____ *Date of Birth:* _____

Address: _____

Employer: _____

Secondary Insurance Company: _____

ID#: _____Policy #: _____Group #: _____

If different from above:

Insured's Name: _____ *SS#:*_____ *Date of Birth:* _____

Address: _____

Employer: _____

Fee and Payment Information

Please read the following information carefully and sign below.

□ The fee is $110.00 per hour for all appointments. Most medical insurance companies will pay a specific percentage of the fee minus your yearly deductible. As a courtesy, our Office Manager will bill your insurance company unless you choose to do so yourself. Insurance is a contract between you and your insurance company. We are not a party to

this contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, or covered charges. Although we make every attempt to help you get payment for these services, it is ultimately your responsibility to know you insurance coverage. You will be responsible for payment of fees not covered by your insurance company.

☐ Payment and/or co-payment is due at the time of service.

☐ Billing for late cancellations and no-shows will be made at the rate of $60.00 and is the sole responsibility of the client. A cancellation is considered late if you do not cancel by 5:00pm on the last business day before any appointment.

☐ I understand that Trish Brown works with a group of independent mental health professionals under the name Human Growth and Training. I understand that this group is an association of independently practicing professionals which shares certain expenses and administrative functions. While this group shares an address and office space, I understand that Trish Brown is completely independent in providing clinical services to me and is solely responsible for those services. Her records are separately maintained and no member of the group can have access to them without my specific, written permission.

☐ I have read the above and I will take full responsibility for payment of fees for services rendered. I also understand and authorize the release of information related to all claims for benefits of myself and/or dependents and for insurance payments to be sent directly to the provider. All information is confidential and will not be released without my permission.

☐ I understand a copy of the HIPPA Privacy Notice can be obtained from Trish Brown's website (www.patriciambrown.com) or I may view and request a copy at any time at the office.

_____ _____

Patient Signature Date