

New Client Information Dr. Peeler

Date: _____

Name: _____

Address: _____

Social Security Number: _____

Phone numbers: Home: _____

Business: _____

Cell: _____

May any of these numbers be used to contact you? **YES** or **NO** (please circle). If "No" is your response which numbers are not to be used?

***Please be advised that if you have caller ID, calls from this office may be identified on you caller ID. If you prefer calls not to be identified as originating from this office, you will have to disable your caller ID

Date of Birth: _____

Occupation: _____

Marital Status _____

Spouses Name: _____

Spouses Occupation: _____ Spouses D.O.B. _____

Previous Psychotherapy? **YES** or **NO** (please circle)

If "yes", give brief information regarding dates, name of previous therapist(s).

Previous psychiatric hospitals? **YES** or **NO** (please circle) If "yes" give brief information including dates, location, reasons hospitalization, name(s) of treating psychiatrist or psychologist

Reason for seeking therapy at this time? May include symptoms you are having and/or current stressors _____

How long have current issues persisted? _____

Name of Referral person or agency: _____

(May the referring person or entity be contacted)? **YES**...or **NO**.

Please List any medications that you are currently taking: _____

Are you currently or have you ever used illegal substances? **YES** or **NO** (if "yes" please give added information such as when, how often etc.)

Do you currently use alcoholic? **YES** or **NO** If "yes" how much do you drink, and how often (regularly or occasionally) _____

Are you currently involved or do you expect to be involved in any legal actions? **YES** or **NO** (please circle) If "yes" please give a brief description _____

Do you have a chronic illness or a physical condition, which affects your mood?

PAYMENT INFORMATION

Who is responsible for your bill? _____

Are you planning on using health insurance for these services? **YES** or **NO**

If you **do not** plan to use health insurance for payment of services, payment will be expected at the time of Each session. The session rate is \$130.00 for a **45-50** minute session. Sessions that last longer than this time period will be pro-rated and additional costs will occur. The initial session is billed at \$150.00.

If you **do** plan to use health insurance for these services:

Have you checked with your carrier regarding eligibility for behavioral health benefits?
YES... Or **NO**. (Please circle)

***Please be advised that if you have Not contacted your carrier and obtained authorization regarding eligibility for benefits, that You will be responsible for the balance on any unpaid or partially paid claims

Co-payments are expected to be paid at each session.

Health Insurance Information

Name of Carrier: _____

Billing Address of Carrier (please note that the billing address for behavioral health may be different from the address for medical services): _____

Phone number information of carrier (may be different for behavioral health services) : _____

Your policy identification number with your carrier: _____

Your policy group number with your carrier: _____

If you are Not the primary person listed on your policy please provide the name, policy identification number, and date of birth of the primary insured:

Name: _____ Date of Birth: _____

Policy number: _____

What is the date of the calendar year for your insurance policy? _____--

What is the deductible for your policy regarding behavioral health services?

****Be advised that You are responsible for any amount of your bill that goes toward your yearly deductible and is not paid by the insurer.

NOTICE FOR ALL CLIENTS, REGARDLESS OF PAYMENT ARRANGEMENTS

*****Any bills for which you are responsible, and which have not been paid in a timely manner, may be forwarded to a collection agency and reported to credit bureaus. This action is a legal exception to your right of confidentiality. Other areas in which rights of confidentiality do Not apply include concerns regarding 1. Harm to others 2. Harm to yourself 3. Sexual or other abuse of children or of the elderly. *****

Other than the above named exceptions, seeking therapy from a licensed psychologist provides you with strict guidelines protecting your confidentiality in the state of Georgia.

Signature of client: _____

Date of signature: _____