Find Peace, Even In The Toughest Situations

Christian Psychotherapy Services

PATIENT INFORMATION

Name_____Date of Birth_____
First Middle Last

Address:_____
Street City State Zip Code

SSN:_____ Home Phone_____ Cell Phone_____

Employer:_____ Employer Phone_____

Employer Address:_____
Street City State Zip Code

How did you hear about us? (Check all that apply)

( ) Telephone listing ( ) Radio (specify)_____
( ) Friend/relative ( ) Church/pastor_____
( ) Shepherd's Guide ( ) Former patient/client_____ ( ) Other (specify)_____

RESPONSIBLE PARTY

Name:_____ Relationship to patient_____ SSN_____
Address:_____ Phone_____
Employer:_____ Phone_____
Spouse's Name:_____ SSN_____
Address:_____ Phone_____
Contact information for closest relative, not living at above address:
Name_____ Relationship_____
Address_____
Home Phone_____ Work Phone_____ Cell Phone_____

INSURANCE INFORMATION: Please show all insurance cards to receptionist.

Primary Insurance Carrier_____Insured Name (on card)_____
ID # on card_____ DOB of Insured_____ Effective Date_____
Secondary Insurance Carrier_____ Insured Name (on card)_____
ID # on card_____ DOB of Insured_____ Effective Date_____
Other Insurance or HMO? ( )Yes ( )No If yes, name of insurance carrier/HMO_____ ID # on card_____

I hereby authorize Christian Psychotherapy Services to release to my insurance company or its representatives, any information regarding my treatment, including diagnosis that is neccessary to process my insurance claim.

I hereby assign all my rights to benefits payable by my insurance company to Christian Psychotherapy Services and thereby authorize and request my insurance company to pay my benefits directly to Christian Psychotherapy Services.

All insurance information has been listed correctly. I understand that if I have any other health insurance coverage, including an HMO that is not listed above, any charges not covered by the listed insurance, will by my responsibility. I understand my co-payment and deductible are due at the time services are rendered. I understand I will be billed for appointments not canceled 24 hours before the scheduled time. I hereby understand I am responsible for all charges incurred during the course of treatment, including any psychological testing or other services not previously stated.

I agree to pay interest at the rate of 33% annum on any unpaid balance if the matter is referred to an attorney for collection and I agree to be responsible for any reasonable attorney fees incurred by Christian Pshychotherapy Services.

_____ _____
(Date) (Signature)

*******PLEASE FILL OUT THE BACK OF THIS SHEET*******

Describe Your Reason for Seeking Help:_____

When were you last examined by a physician?_____

List any major health problems for which you currently receive treatment:_____

List any medications you are currently taking:_____

Have you ever received psychiatric or psychological help, or counseling of any kind before?_____
If you have, please explain:_____

Please circle any of the following problems which pertain to you:

Nervousness	Depression	Fears
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Trouble
Bowel Troubles	Being a Parent	My Thoughts

List the memebers of your family and all others in your home:

Name	**Age/Birth Date**	**Relationship**	**Occupation**

Please add any additional information that you feel may be useful to us:_____

Thank you for completing this questionnaire.