FULL NAME_____DATE OF BIRTH_____

ADDRESS_____SOCIAL SECURITY_____

CITY, STATE & ZIP CODE_____

HOME PHONE_____CELL_____

SOCIAL HISTORY:

RELATIONSHIP STATUS: S M D W

ARE YOU CURRENTLY EMPLOYED:_____IF YES, WHERE?:_____

PLEASE LIST ALL MEDICAL PROBLEMS WITH APPROXIMATE YEAR DIAGNOSED (USE BACK FOR MORE SPACE IF NEEDED)

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE LIST ALL PRESCRIPTION MEDICATIONS THAT YOU TAKE- INCLUDING DOSAGE AND HOW OFTEN, INCLUDE AS NEEDED MEDICATIONS, OVER THE COUNTER MEDICATIONS AND ALL VITAMINS, MINERALS, AND HERBAL SUPPLEMENTS. YOU MAY USE THE BACK FOR ADDITIONAL SPACE.

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICATION ALLERGIES:

_____ _____ _____

_____ _____ _____

PLEASE INCLUDE ALL PHYSICIANS THAT YOU SEE ON A REGULAR BASIS, INCLUDING PRIMARY CARE/ FAMILY PHYSICIAN:

_____ _____ _____

DID YOU HAVE ANY PREVIOUS TREATMENT? YES NO

WHEN: WHERE:

CALLOWHILL FAMILY THERAPY HIPPA MEDICAL RELEASE INFORMATION

We are required by law to maintain the privacy and personal health information and to provide you notice of our legal duties and privacy practices and adhere to this notice.

This notice describes how my protected medical information may be used and disclosed and may be given a copy if requested. Please review carefully.

Please list names of any person(s) whom we may inform about your general medical condition and your diagnoses (including treatment, payment and healthcare operations).

NAME **RELATIONSHIP** **PHONE NUMBER**

CONTACT INFORMATION

May we contact you at home? YES NO phone number _____

May we leave a confidential message

(i.e. appointment reminders

Etc.) on your answering service? YES NO phone number _____

Would you like us to have your e-mail

On file for future correspondence YES NO email address _____

PATIENT NAME_____

SIGNATURE_____**DATE**_____

(if minor, signature of parent/guardian)

CALLOWHILL FAMILY THERAPY

CONSENT TO TREATMENT

I _____hereby give my permission to the staff of CALLOWHILL FAMILY THERAPY to conduct evaluation and treatment services as deemed necessary to assist in the alleviation of any diverse psychological conditions, or any conditions associated with my use of alcohol and/or drugs if applicable.

ALSO, I realize that written records will be kept on me and that information will be requested from me periodically, to ascertain by progress. Such data will be kept confidential, and no information which might identify me will be released without my written consent, except in the case of medical emergency.

FURTHERMORE, I understand that I have the right to refuse any recommended treatments, and my privilege to discuss any forms of potential treatment and possible ill effects with the staff of CALLOWHILL. I understand that I am entitled to a full explanation of any prescribed procedure and that CALLOWHILL and staff are obligated to discuss with me, and gain approval, on all established treatment plans before such plans may be instituted.

IN ADDITION, the criteria for admission, treatment completion and discharge has been fully explained to be by the interviewing staff person. I, also, have been made fully aware of the facilities policies, hours of operation, patient fee schedule and services provided.

DATE:_____

SIGNATURE:_____

WITNESS:_____

CANCELLATION POLICY

We consider an appointment to be a commitment and an agreement. When an appointment is scheduled, the time is set aside for you and no one else. Consequently, unlike other doctors' offices, we do not double or triple book patients. However, in order to do this, we must charge a fee for all appointments not cancelled within 24 hours of the appointment.

If your appointment falls on a Monday, you may leave a message with the answering service over the preceding weekend.

In today's busy world, unplanned issues arise for all of us. However, we politely request that appointments which you are unable to honor are appropriately cancelled so that we may offer them to someone else who may need an appointment.

CANCELLED APPOINTMENTS – No charge will be made for any appointment with at least 24 hours advance notice.

MISSED APPOINTMENTS – An appointment cancelled on less than a 24 hour notice, or an appointment missed without a notice of cancellation, will be billed a cancellation fee. THIS FEE WILL NOT BE CHARGED TO YOUR INSURANCE AND IS YOUR RESPONSIBILTY TO PAY IN FULL PRIOR TO RESCHEDULING.

EXCEPTIONS - Same day cancellations because of serious medical/family emergencies or dangerous road conditions (snow/ice) will not be charged as long as a telephone call is received in the office before the scheduled appointment time.

FEES –	COUNSELING	$40.00
	MEDICATION CHECKS	$55.00
	PSYCHIATRIC EVALUATIONS	$125.00

I am aware of the cancellation policy and agree to the terms.

_____

Signature/Patient or Guardian Date

Credit Card Authorization Form

tebra

The undersigned agrees and authorizes the medical practice to save the credit card indicated below on file.

Merchant Name Callowhill Family Therapy PC

Patient Name _____

Card Information

Card Type ☐ Visa ☐ Discover ☐ MasterCard ☐ American Express

Cardholder Name (as it appears on the card) _____

Last 4 Digits of Card _____ Exp Date (MM/YYYY) _____

I, _____ , authorize the above medical practice to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. I may also revoke this form by submitting a written request to the medical practice.

Please call office to give full card number

Payment card must be on file for ALL telehealth appointments before services are rendered

Your co-payment is due at the time of visit

Cardholder Signature _____ Date _____