

Adult Client Information Form

Name: Last _____ First _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____ Is it okay to contact you by email ? _____

Birth Date: _____ Social Security # _____ Sex: M _____ F _____

Marital Status: Married _____ Single _____ Divorced _____ Live-In _____

Insured's Employer's Name: _____ Insured's Employer's Address: _____

Primary Insurance: _____ Policy Number: _____

Name of Insured & Relationship to Client _____ Group#: _____

Address of Insurance Company: _____ Phone # _____

Secondary Insurance: _____ Policy Number: _____

Name of Insured & Relationship to Client: _____ Group #: _____

Address of Insurance Company: _____ Phone # _____

Consent to Treatment

I acknowledge that I have reviewed and understand my rights in the therapeutic relationship as described in the document "Client Information" and have been given the opportunity to ask any questions regarding this process. I consent to take part in the treatment by Julie Luzarraga, LCSW. I understand that the practice of medicine is not an exact science and I acknowledge that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. I understand that I am financially responsible for my treatment as the patient, guardian, conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance or out-of-pocket expenses. **I understand that I must call to cancel an appointment at least 24 hours before the time of the appointment. I understand that I am responsible for a \$60 charge for no-shows and a \$45 charge for canceling within 24 hours of a scheduled appointment. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), and providers of any services or treatment I receive.** However, I understand that I am responsible for the payment of services. I understand that if payment for the services I receive is not made the therapist may stop my treatment. I have been given a copy of Julie Luzarraga's Notice of Privacy Practices for Protected Health Information ("Notice of Privacy Practices"). I understand that Julie Luzarraga has the right to change the Notice of Privacy Practices at any time. I may obtain a current copy of the Notice of Privacy Practices at 8021 Chicago Street, Omaha, NE 68114. The undersigned does hereby acknowledge receipt of the Notice of Privacy Practices. The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, or is duly authorized to execute the above and accept its terms.

Patient's Signature/ Guardian		Date
Responsible Party's Relationship to Patient	Insured's Signature	
Witness to Signatures	Patient Unable to Sign Consent Because	

Dx Code (To be entered by therapist): _____

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Who referred you: _____

Reason for referral: _____ May I thank him or her? _____

Please list any medical problems: _____

Please list any medications you are taking: _____

Please list the names and ages of any other members of your household: _____

Emergency Contact Information (Name and telephone number): _____

Other Providers Involved in Your Care:

Provider's Name

Address

Phone

Would you like to be added to our email list for upcoming events and groups? _____

Please provide the email address you'd like us to use _____

For Office Use Only