

Create A Healthy Mind New Client Information Form

Name of Client/Patient: _____ Date of Initial Session: _____
Date of Birth: _____ Referred by: _____
Home Address: _____ City: _____ State: _____
Zip: _____ Home phone: _____ Work phone: _____
Emergency phone contact (cell) _____
Parent(s) if under 18: _____
School (if student): _____ Year in School: _____
Primary Teacher (if Elementary School): _____ Phone: _____
Name of Insured: _____ DOB of Insured: _____
Employment: _____ Occupation: _____
ID number of Insured: _____ Group# _____
Mailing Address of Insured (if different from above): _____

Co-pay: _____ Deductible: _____ Co-insurance: _____
Primary Care Physician: _____ Phone: _____
Person other than self to call in an emergency: _____
Phone number of emergency contact: _____

General Information Regarding Services:

I am available to schedule appointments between 8:30 am. and 5pm Monday through Friday. We will generally meet for fifty minutes at a time. However the initial evaluation or session can last up to two hours if testing is included. My standard fees are between \$150.00-\$250.00 for an initial consultation or diagnostic interview, \$90.00-\$150.00 for a standard fifty-minute therapy session, and \$150.00 for one hour of professional supervision. Psychological testing can range between \$450.00 up to \$5,000.00 depending on the nature and quantity of the tests involved and the amount of family members that need to be evaluated. For testing, all fees must be paid as soon as the data is obtained and before the writing of any written reports. I have a sliding scale for those who need it.

Please Sign Below after reading notice of privacy practices:

I, the undersigned, agree to be financially responsible for the treatment I receive. I may use health insurance to pay for part or all of this treatment in accordance with any contracts that Create A Healthy Mind might have with my insurance company. However, if there is no specified contract in operation, or if the insurance company fails to pay for it's portion of my treatment, I will be responsible for paying my bill in full at the end of each session I attend. I further agree to pay in full for any missed appointments unless I either give 24 hours notice of cancellation, or am unable to attend due to being medically contagious, or having to take care of a person in my care who is seriously ill and needs supervision. Patients are not permitted to use email to cancel or reschedule appointments. Finally, should it be requested in writing, I give Dr. Parks permission to provide diagnostic information to my insurance company. I, the undersigned, have thoroughly read the privacy practices for Create A Healthy Mind as well as the General Information Regarding Services, and agree to their terms.

Client or Legal Guardian (if under 18) date signed

Witness Signature

date signed