NEW PATIENT INFORMATION

Please note: Information you provide here is protected by HIPPA laws as confidential information.

Patient Information (Please Print Clearly)
Name:

First MI Last

Mailing Address:

Street Name # or PO Box City County State Zip Code

Physical Address (if different):

Street Name # or PO Box City County State Zip Code

Phone Numbers:

Home: Business:

Cell:

Sex: Male ☐ Female ☐

Patient Date of Birth:

Relationship Status:

☐ Single ☐ Married ☐ Widowed ☐ Separated

Highest grade completed:

☐ Domestic Partner ☐ Other

Employment: ☐ Full-Time ☐ Part-Time

_____

Education: ☐ Full-Time ☐ Part-Time

_____

Who referred you to Love Thy Self Counseling & Services?

_____

Do I have your permission to receive emails and/or text messages? ☐ Yes ☐ No

(Please note email or text is not HIPPA protected and is not for the replacement of therapy.)

Email Address:

_____

Spiritual Belief:

Do you have particular faith that you identify with? If so, which one?

_____

Would you like Christian Counseling to be integrated into your therapeutic process? ☐ Yes ☐ No

Diet & Exercise:

_____

Medical Billing:

_____

Sponsor's Name:

_____

Sponsor's SSN:

_____

Emergency Contact:

Name:

_____

Contact Number:

_____

Parent/Guardian Information (must be completed by parent/legal guardian if patient is a minor or not responsible for payment.)

Responsible Party #1 Name: _____

Relationship:

Parent ☐ Legal Guardian

Address:

_____

Phone Number:

_____

Responsible Party #2 Name: _____

Relationship:

Parent ☐ Legal Guardian

Address:

_____

Phone Number:

_____

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please list medications:

_____

Are you, or have you been, involved in counseling/psychotherapy? Yes ☐ No ☐

If yes, please indicate the date of last involvement and the provider's name, address, and telephone number.

Provider's Name:

_____

Provider's Telephone Number:

_____

Provider's Address:

_____

Have you ever been hospitalized for problems relating to emotional issues? ☐ Yes ☐ No

If so, please indicate the location and the dates of the hospitalization.

_____

Have you ever received treatment for alcohol and /or other drug dependency? ☐ Yes ☐ No

If so, please indicate the date and location of treatment.

_____

Are you currently involved with any legal matters? ☐ Yes ☐ No

If yes, please explain.

_____

_____

Are you currently involved in a disability or workman's compensation claim? ☐ Yes ☐ No

If yes, please explain.

_____

_____

Do you have children? Yes ☐ No ☐

If so please list there names and ages.

_____

_____

_____

Emergency Contact:

Annual household income:

Do you rent or own:

If you are paying with a credit/debit card please indicate if you would like me to hold the card on file or will you be paying at each session?

Please list the Credit card number here:

Expiration:

CVV Code:

Billing Zip Code:

Name on the Card:

For credit cards there is a 3.5% fee) You may also pay via Zelle, Cash or Check.

Chief Concern:

Please describe the main difficulty that has brought you to see me
(include symptoms and length of time):

What are your goals for therapy?

_____

Please indicate any fears about having therapy:

_____

_____

_____

Please indicate the following symptoms if they apply now:

☐ Shortness of breath ☐ Concerns about food or body ☐ Sleep Disturbances

☐ Restrict food intake ☐ Elevated heart rate ☐ Guilt or shame after/ while eating

☐ Depressed Mood ☐ Purging ☐ Anxious Mood ☐ Lack motivation

☐ Depressed Mood ☐ Suicidal thoughts ☐ Concerns about alcohol or drug use

Do you currently attend or have you ever attended any 12-step program? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Please list any hospitalizations or inpatient treatments:

_____

_____

Have you ever attempted suicide? ☐ Yes ☐ No

When?

_____

Describe the circumstances that led to that attempt:

_____

_____

_____

Previous Psychotherapist: Phone Number:

_____ _____

Reason for treatment:

_____

Dates: Phone Number:

_____ _____

Cancellation Policy

In order for the therapy process to be most effective, it is important to keep regular sessions as scheduled. As I do understand emergencies arise, I require 24-hour notice for a session cancellation. If there is less than 24 hours notice, I do charge the full rate for the session. By signing below, you are indicating that you have read and understood the stated Cancellation Policy. Thank you for your cooperation.

Client Signature: Date:

_____ _____

Therapist Name: _____ Date: _____

I will pay for today's fee and all other incurred fees - (Copays, Deductibles, or Coinsurance) with ☐ Cash ☐ Personal Check ☐ Visa/MasterCard/Discover ☐ Tricare or Other Insurance ☐ Other

I hereby authorize payments of my insurance benefits for services provided be made to LTS Services. I understand that these payments will be applied directly to my psychotherapy bill. I understand that I am responsible for the co-payment and any deductible, and that ultimate responsibility for payment of fees for psychotherapy at these offices is mine. I further authorize the release of any and all information to my insurance company that is necessary to process and pay for my claim for services. I understand that this information is confidential but may be required by my insurance company in order to process my claims. I may refuse release of this information if I do not wish for my insurance to be billed for these services. I release LTS Services from any responsibility in the insurance company's management of the confidential information.

Name: _____ Date: _____

Signature of patient (Or parent/legal guardian if patient is a minor or not responsible for payment) lovethyselfservices@gmail.com