

Riverview Psychological Services, P.C.
New Client Information

FOR INTERNAL USE

Therapist Name: _____ Location: _____

Client Name: _____ DOB: _____ SS#: _____

Address: _____ Tel: _____

Insurance Co: _____ ID#: _____ Grp#: _____

Subscriber's Name: _____ DOB: _____ SS#: _____

Current Physician name/telephone: _____ / _____

Current Diagnosis/ Medications: _____

Reason Seeking Treatment: _____

Previous Treatment History: _____

Current home environment: _____

Supports: _____

Cancellation, Payment, Re-scheduling Policy: I hereby certify that the subscriber listed in this document has active behavior health coverage with the above-named insurer. My signature below is providing express consent to assign all insurance benefits from this company, in relationship to this treatment, otherwise payable to me, directly to Riverview Psychological Services, P.C. I further understand that if the subscriber's behavioral health coverage is denied or terminated during the course of treatment, I am completely responsible for all payments of any services rendered. This includes co-payments and deductibles that are not reimbursed through the subscriber's insurance policy. I hereby authorize Riverview Psychological Services, P.C. to release all information necessary to secure the payment of benefits. I authorize the use of the signature below on all insurance submissions, whether manually or electronically. In regard to the cancellation/no show policy, I understand that 48 hour notice is required to change or cancel an appointment. I understand that a \$50.00 "time reserved" charge may be applied for cancellations/no shows that occur within the 48 hour window.

A copy of our Notice of Privacy Practices "HIPPA form" has been made available to me..... initial _____

I give consent for treatment deemed necessary or beneficial by my clinician for my well being..... initial _____

Patient/Guardian Signature / Print Name / Date