Alamo Area Counseling & Behavioral Associates.P.C.
4242 Piedras Dr. E. Ste #114
P: 210-310-3212 F: 210-800-9916

PATIENT INFORMATION

**** Any changes to your phone number, address, or insurance should be reported to the front desk** <u>** Acceptable Forms of Payment: DEBIT OR CREDIT CARD ,CASH NO CHECK**</u>**

Patient Full Name:	Today's Date:
Patient DOB:	Patient SSN:

Legal Orders

Is this patient documented in any legal documentation such as but not limited to: Divorce Decree, Custody Orders, Adoption Documentation, Power of Attorney, etc Yes No **If yes, please indicate the nature of the documentation and provide a copy to the Front Office for our records.**

Legal Guardian(s)/Parent(s):

Name and DOB:	Contact Number:
Relationship to Patient:	
Name and DOB:	Contact Number:
Relationship to Patient:	

<u>Patient Information (Circle One)</u>

Gender: Female Male Other:	Language: English Spanish Other:	Is an interpreter needed: Yes No
Hearing or Visual Impairment: Yes No	If yes, please indicate the nature of impairment:	

Religious Preferences:	Christian	Catholic	Jewish
	Islam	Atheist	Other
Marital Status:	Single	Married	Divorced/Separated
	Widowed	Child/Adolescent	Other:
Employment Status: Employed Full Time Student Part Time Student Unemployed Other:			

<u>Patients' Residential Address</u>

Address:			
City:	State:	Zip:	
Email:		Contact Number: (Circle your preferred)	
		Cell Phone:	
		Home Phone:	
Preferred Method for Reminders:	Email	Text	Phone Call

<u>Emergency Contact</u>

Name:	DOB:
Contact Number:	Relationship to Client:

Let us know who we can thank for referring you to our center (circle how you were referred):

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Google/Internet	Psychology Today	Insurance	TV/Commercial
Friend/Relative	Doctor's Office (please name):		Other (please specify):
Are you interested in receiving a psychological evaluation for further diagnosis and treatment recommendations? (circle one) Yes or No			
The fee for missed appointments and cancelled appointments with less than a 24 hour notice will be $75. The fee for missed appointments for testing will be $100. The Fee For Missed BSFT Session is $175.00			

Insurance Information

In order for our center to bill your insurance, this form will need to be completed in full in addition to providing the Front Office with a copy of your insurance card.

Primary Insurance Carrier Name:		
Member ID:	Group ID:	
Are you (the patient) the Primary Insured to this policy: Yes No		
Primary Insured Name and DOB:		
Primary Insured Address:		
City:	State:	Zip:
Contact Number:		

If any additional insurance, please list below:

Secondary Insurance Carrier Name:		
Member ID:	Group ID:	
Are you (the patient) the Primary Insured to this policy: Yes No		
Primary Insured Name and DOB:		
Primary Insured Address:		
City:	State:	Zip:
Contact Number:		

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Patient Care Form: Coordination of Services

The purpose of this form is to coordinate with your primary care physician to ensure we are able to provide the most effective standard of care.

Primary Care Physician (PCP) Name:		
PCP Office Name:		
Office Number:	Fax Number:	
Office Address:		
City:	State:	Zip:

Patient Name:	**DOB:**

Patient, please check one:

- **I agree** to release information to my physician listed above
- **I do not agree** to release this information to my physician listed above.
- **I do not have** a primary physician.

This consent shall expire one (1) year from the date of signature. I understand I may revoke my consent in writing at any time except to the extent that action has already been taken in reliance on it.

Patient or Legal Guardian Signature:_______________________________ Date: __________

Authorization to Disclose Information

To the party receiving this information: This information has been disclosed to you from records whose confidently is protected by federal law. Federal regulations 42 CFR Part 2 prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

Your patient was seen at Alamo Area Counseling and Behavioral Associates for an initial assessment on __________________ and a future appointment has been scheduled for _______________.

The diagnosis and presenting problem discussed: ____

____.

Treatment Recommendation: ____

____.

Additional medical history and medications discussed:____

Please contact our office to speak to me, if further information would be helpful to the clients treatment.

Sincerely,

____

Clinician Signature & Date