Amy Riehle

Licensed Clinical Social Worker
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NEW CLIENT INFORMATION

Name**:**_____ Birthdate:_____

Social Security No._____

Address: _____ City, State_____

Zip Code:_____ Phone:_____ Cell

Phone:_____ Whom May I thank for referring you?

_____

If the client is a minor, Mother's name:_____ DOB:_____

Father's name:_____ DOB:_____

Person Responsible for this account: _____

Social Security No._____

Client/Guardian's Employer:_____ Bus. Phone:_____

Person to Notify in Case of an Emergency:_____

Relationship:_____ Phone:_____

How is the best way to contact you?_____

Is it okay for me to leave a message for you at home?	YES	NO
Is it okay for me to contact you at work?	YES	NO
May I leave a message for you at work?	YES	NO
May I leave a voicemail message?	YES	NO
Is it okay for me to text message you?	YES	NO
May I e-mail you?	YES	NO

Please read the section in the Welcome Letter/-Consent Information File which explains the limits to confidentiality when using Telecommunications.

Please Read Carefully: Payment/Co-Payment is due at the time of services. You are responsible for calling your insurance company to confirm that Amy Riehle, LCSW will be covered by your policy and get any pre-authorization that may be required by your Insurance Carrier to cover services provided. The client or guardian is responsible for all fees, regardless of insurance coverage.

INSURANCE INFORMATION

Insurance Carrier:_____

Policy Holder's Name:_____ DOB:_____

Policy Holder's Social Security Number:_____

Insurance Carrier: :_____

Insurance Policy No:_____ Group No:_____

Plan No:_____ Has your deductible been meet?_____

Co-Payment Amount:_____

Have you received pre-authorization from your insurance company?_____

No. of Sessions Authorized:_____ Authorization #_____

Insurance Carrier:_____

Other Insurance:_____ Policy Holder:_____

Insurance Carrier: :_____

Policy #:_____ Plan #:_____ Group:#_____

Has the Deductible been met?_____ Co-Payment amount?_____

AUTHORIZATION/CONSENT TO TREATMENT

I hereby consent for Amy Riehle, LCSW to provide evaluation and treatment. I grant authorization to Amy Riehle, LCSW to release any Protected Health Information (except Psychotherapy Notes) to my insurance company that is necessary for billing or to process my claim for payment of services. I authorize my insurance company to send payment directly to Amy Riehle, LCSW for all services provided. I understand that I am financially responsible for all services not covered by insurance. I agree that a photocopy of this authorization shall be valid as the original. My signature below also indicates that I received the HIPPA Notice Form and the Client Service Agreement. I understand that there can be no absolute cure in the practice of Psychotherapy.

Signature:_____ Date:_____

Relationship to Client if Client is a Minor:_____