

ALLIED MENTAL HEALTH SERVICES

PATIENT INFORMATION SHEET

List Patient on 1<sup>st</sup> line, then ALL other

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Family Members Living at Home

Name	Sex	Age	Birth Date	Marital Status	Religion	Education Level	Occupation	Social Security #

Patient's Home Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Patient's Place of Birth \_\_\_\_\_ # of Years at Present Address \_\_\_\_\_ E-mail Address \_\_\_\_\_

Patient's Employer or School \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Current Medications Taken & Dosage Levels \_\_\_\_\_

Presenting Problem(s) of Patient \_\_\_\_\_

Date of Patient's Last Physical Exam \_\_\_\_\_ Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Patient's Previous Mental Health Treatment Experience (Include dates, clinicians & outcome) \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_ Phone #, if known \_\_\_\_\_

How are Today's Fees Being Paid? \_\_\_\_\_ Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_ EAP \_\_\_\_\_ Insurance \_\_\_\_\_

THIS SECTION FOR CHILD & ADOLESCENT PATIENTS

Who has Legal Custody of Patient? \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Divorce if Applicable \_\_\_\_\_

Custodian's Address & Phone # if Different than Patient's \_\_\_\_\_

Consent for Treatment: I, (print name) \_\_\_\_\_, give permission for treatment of the minor child over whom I have Legal Custody and the right to seek treatment.

Signature of Legal Guardian

THIS SECTION FOR ADULT PATIENTS

If Married, for How Long? \_\_\_\_\_ years Spouse's Employer \_\_\_\_\_ Address \_\_\_\_\_

Is Spouse Currently Being Treated for Any Mental or Emotional Condition? \_\_\_\_\_

If Divorced, When? \_\_\_\_\_ How Many Years Married? \_\_\_\_\_ Previous Maiden / Married Name \_\_\_\_\_

Please list all current and past family members treated for emotional or addiction problems:

Family Member	Dates of Treatment	Problem(s) Treated

Please list all family members who take drugs, including alcohol and prescription medicines in any amount or frequency:

Family Member	Drug, Alcohol, Medication Taken	Amount Taken Daily (or weekend), Dosage Level & Frequency

ALL PATIENTS PLEASE COMPLETE BACK SECTION

**INSURANCE INFORMATION**

Please let us make a copy of your insurance card. We will also need a signed claim form.

Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_ Ins Membership # \_\_\_\_\_  
 Date of Birth \_\_\_/\_\_\_/\_\_\_ Relationship to Patient \_\_\_\_\_ Employer \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_ Group Policy or Account # \_\_\_\_\_  
 Phone # to Verify Benefits \_\_\_\_\_ Authorization or Certification # \_\_\_\_\_ EAP? \_\_\_ yes \_\_\_ no

**RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS**

I authorize this office to release any information requested concerning me that will allow for processing of insurance or EAP claims. I directly assign any and all benefits payable to Allied Mental Health Services or Marty Lerman, Ph.D. I understand I am responsible for all fees, regardless of insurance coverage. I agree to pay AHMS any fees not paid by insurance or EAP after 60 days of filing.

Signed by Patient or Responsible Party, if Patient is under 18 years of age \_\_\_\_\_ Date \_\_\_\_\_

**BROKEN APPOINTMENT POLICY**

I understand that by making an appointment for professional services I am reserving time with Dr. Lerman that is exclusively my time. In the event I am unable to keep an appointment I will notify Dr. Lerman's office by phone at least one full business day before the appointment. I agree to pay Allied Mental Health Services or Marty Lerman, Ph.D. the cost for the broken appointment should I fail to keep the appointment. The cost will be one half Dr. Lerman's normal fee for a clinical session. I agree to pay this cost at my next appointment or within 7 days of the broken appointment, which ever occurs first.

Signed by Patient or Responsible Party, if Patient is under 18 years of age \_\_\_\_\_ Date \_\_\_\_\_

**PAYMENT AGREEMENT**

I am aware that insurance benefits quoted over the phone are not a guarantee of payment. At the time of service I agree to pay Allied Mental Health Services or Marty Lerman, Ph.D. for all fees applied to deductibles, co-payments, or the portion of the fee not covered by insurance. I agree to make good on all payments whether by cash, personal check, debit card or credit card. I waive any claim or right to stop payment on personal checks or dispute any credit card or debit card charge once accepted for payment. Should the bank return my personal check for any reason, I agree to pay Allied Mental Health Services or Marty Lerman, Ph.D. that amount, plus \$25.00, in cash or by money order within 3 days of notification. Should my debit card or credit card deny payment for any reason, I agree to pay Allied Mental Health Services or Marty Lerman, Ph.D. that amount in cash or by money order within 3 days of notification.

Signed by Patient or Responsible Party, if Patient is under 18 years of age \_\_\_\_\_ Date \_\_\_\_\_

**LATE FEES**

In the event an outstanding balance exists on your account we will send you a statement by mail or email. Payment is due when you receive the statement. If no payment is received within 20 days a \$10.00 late fee will be assessed. You agree to pay this late fee unless you contact Dr. Lerman before the 20 days goes by and a mutual agreement is worked out. You further agree to pay additional late fees of \$10.00 each month a balance remains on your account after the first statement is mailed to you. You further agree to notify us of any change to your mailing address or phone number changes.

Signed by Patient or Responsible Party, if Patient is under 18 years of age \_\_\_\_\_ Date \_\_\_\_\_

**\* FOR OFFICE USE ONLY \***

Verification of Benefits: Date \_\_\_\_\_ Time Called \_\_\_\_\_ Ins Rep \_\_\_\_\_  
 Mental Health Carrier \_\_\_\_\_ Effective Date of Policy \_\_\_\_\_ Pre-Auth Required \_\_\_\_\_  
 EAP: Authorization # \_\_\_\_\_ Authorized Visits \_\_\_\_\_ Benefits \_\_\_\_\_  
 M/C: Authorization # \_\_\_\_\_ Deductible \_\_\_\_\_ Annual Visits \_\_\_\_\_ Authorized Visits \_\_\_\_\_  
 Co-Pay \_\_\_\_\_ Benefits \_\_\_\_\_  
 OTR Instructions \_\_\_\_\_  
 Claim Mailing Address \_\_\_\_\_  
 Other Information \_\_\_\_\_