Patient Information - *Please complete every field.*

Full Name:_____DOB:_____

Home Address: _____

City, State, Zip: _____

Home Phone #:(_____)_____Other Phone #:(_____)_____

Social Security #:_____

Emergency Contact:_____Phone Number:_____

I may be contacted by: ____Mail ____Phone ____In person ____None, A message may be left with (specify): _____

*Email address where we may send any required EAP forms: _____

Subscriber's Managed Care Insurance – *Please attach a copy of the front a back of your insurance card.*

Insurance Company: _____

Insurance Phone # (On your card there is usually a specific number for mental health providers to call): _____

Subscriber's Name & Relationship to Patient: _____

Subscriber's Insurance ID #: _____Subscriber's Policy Group #: _____

Subscriber's Social Security #: _____ Subscriber's Date of Birth: _____

Subscriber's Employer: _____

EAP*- *Our office may email or call you regarding special forms required by your EAP. Please complete immediately to insure coverage.*

EAP Company:

EAP Company Phone #:

EAP Authorization #:

Authorization of Payments: I hereby authorize payment of insurance benefits to Jessie Rayl, LPC for services rendered to me. I understand that this authorization will remain in effect unless I terminate the authorization in writing. I understand if I do not elect to use my insurance I will be billed according to UCR ($150.00 per hour). I understand I am responsible for all co-payments and deductibles according with my insurance provider.

Cancellations: I understand and agree that a 24 hour notice is required for cancellation of a session.

EAP: Forms may be signed by the provider in the absence, or failure to return, of the client. I understand I may request a copy of this form. I understand that once I have exceeded allowable sessions from my EAP, I may (1) be able to continue treatment with this therapist using my managed care insurance, UCr or flat rate; or, (2) if I wish to continue treatment and not with this therapist, or in the event my EAP does not allow self referral, this therapist will make appropriate referral elsewhere.

Self-Pay: I understand I will be charged per session as indicated in the "financial" of Consent Form. This is a flat rate and discounted to those who cannot afford the usual customary rate ($150) per session. It does not include costs of court.

Office Policy and Privacy Policy: I have been offered a copy of this office's policies and understand these policies.

My signature below indicates that I have read the above notes, provided the above requested information and it is complete to the best of my knowledge. I have been given an opportunity to ask questions and clarify information.

Signature:_____Date:_____