Jennifer Golia, LMFT P.L.L.C.
Family, Couples and Individual Therapy

CLIENT INFORMATION

NAME_____DATE _____

DATE OF BIRTH_____

HOME
ADDRESS_____ZIP_____

MAILING
ADDRESS_____ZIP_____

TELEPHONE (Home)_____

(Work)_____(Cell)_____

OCCUPATION_____, _____ HOW LONG_____
(TITLE) (EMPLOYER)

SS#_____

EDUCATION ____high school ____college ____ post-graduate

RELIGION_____

RELATIONSHIP STATUS __single __committed __married __separated __divorced __ widowed How long_____

PARTNER/SPOUSE NAME_____ DATE OF BIRTH_____
OCCUPATION_____

OTHERS LIVING IN THE HOME (names/ages/how related/occupational or school status for each)

PERSONAL PHYSICIAN _____ PHONE # _____

LAST PHYSICAL EXAM _____

CURRENT MEDICAL
PROBLEMS/SYMPTOMS_____

PAST MEDICAL PROBLEMS/HOSPITALIZATIONS

_____

CURRENT MEDICATIONS

_____

PREVIOUS PSYCHOTHERAPY (therapist/location/dates)

_____

REFERRED BY

_____

EXPECTED OUTCOMES/GOALS/HOPES IN SEEKING PSYCHOTHERAPY

Financially Responsible Party
Name: _____ Relationship to client: _____
Phone (if different from above): _____
Address (if different from above): _____
Which payment type? (mark one) _ Private Pay _ Out-of-network _ Insurance
_ HSA/Flex Fund _ Victim Assistance Fund _ EAP
_ Other Third Party Payer, describe _____
_____

Insurance Information
Policyholder Full Name: _____ D.O.B: _____
Social Security #: _____ Employer: _____
Insurance Plan: _____ Group #: _____
Policyholder ID #: _____ Phone # benefits: _____
Identified Client ID #: _____
Claims Billing Address: _____
_____
Co-pay amount: $____ Co-insurance $____ Deductible amount $_____ met? Y N
If N, remaining deductible? $_____
Ins. Contact Name: _____
Ins. Contact Phone #: _____ext. _____ Fax #: _____
Insurance Authorization #: _____ # of sessions authorized: ____
If applicable, authorization period, from _____ (date) to _____ (date)
Is there a secondary insurance? ____ Y ____ N
Insured's Name: _____ Insured's Social Sec. #: _____
Insured's D.O.B.: _____ Group/Policy #: _____

Emergency Contacts
Name: _____ Telephone #: _____
Name: _____ Telephone #: _____
(By filling in emergency contact person information I authorize Jennifer Golia, LMFT to contact this person in an emergency.)

Client Authorization

I understand that I am fully responsible for any fees for professional services provided to me or my dependents. If I am using my insurance, my signature below authorizes Jennifer Golia, LMFT to submit claim forms for me directly to my insurance company, but does not guarantee payment of claims. I authorize the release of any medical or other information required by my insurance company to receive authorization for services or to process claims for services to me or my dependents. **I am also aware that I must provide 24-hrs notice prior to cancelling an appointment, or I am responsible for the $50 late cancellation fee.**

Signature: _____ Date: _____

Signature: _____ Date: _____

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. How your therapist may use and disclose your information.

I use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred, but only with your written permission. If you sign an authorization to disclose information, you can later revoke it to stop any future uses and disclosures.

2. Your rights.

In most cases, you have the right to look at or get a copy of your health information that I use to make decisions about you. If you request copies, I may charge you a reasonable fee. If you believe your health information is incorrect or information is missing, you have the right to request that I correct the existing information or add the missing information.

3. Therapist's legal duty.

I am required by law to protect the privacy of your health information, provide this notice about privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. You can also request a copy of the notice at any time.

4. Privacy complaints.

IF you are concerned that I have violated your privacy rights, privacy policies, or if you disagree with a decision I make about access to your health information, you may contact the N.H. Board of Mental Health or send a written complaint to:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Room 509 F, HHH Building
Washington, D.C. 20201

Acknowledgement of receipt of Notice of Privacy Practices:

Please print and sign you name below to acknowledge that you have received the Notice of Privacy Practices.

_____

Print name Signature Date

_____

Witness name Signature Date