DR LEE MORAND AND ASSOCIATES LLC

PATIENT INFORMATION

DATE: _____

NAME: _____

(*First, Middle, Last*)

DATE OF BIRTH: _____AGE: _____

GENDER ASSIGNED AT BIRTH: (M) _____ (F) _____

MAILING ADDRESS: _____ APT #: _____

(*City, State, Zip*) _____

EMAIL ADDRESS: _____

PHONE: (H) _____ (C) _____

PRIMARY PHONE: (H) _____ (C) _____ OK TO LEAVE MESSAGE: (Y) _____ (N) _____

FACETIME PHONE: _____

SECONDARY CONTACT (*Minor*) NAME: _____

PHONE: (H) _____ (C) _____

RELATIONSHIP TO CLIENT: _____

REASON FOR SEEKING SERVICES: _____

_____

INSURANCE INFORMATION

(*A copy of your insurance card/proof of insurance is required*)

NAME OF INSURANCE COMPANY: _____

IDENTIFICATION NUMBER (*On Card*): _____

GROUP NUMBER (*On Card*): _____

NAME OF PERSON CARRYING INSURANCE: (*Self*) _____ (*Other*) *_____

EMPLOYER THROUGH WHOM INSURANCE IS CARRIED: _____

*RELATIONSHIP TO CLIENT: _____

*THEIR DATE OF BIRTH: _____ *GENDER: M _____ F _____

Address/Phone if different from client

*MAILING ADDRESS: _____ APT # _____

(*City, State, Zip*) _____

*EMAIL ADDRESS: _____

*PHONE: (H) _____ (C) _____

AUTHORIZATION

PLEASE INITIAL AND SIGN BELOW:

I AUTHORIZE DR LEE MORAND & ASSOCIATES LLC TO RELEASE MY MEDICAL INFORMATION TO MY INSURANCE COMPANY, REFERRING PHYSICIAN AND/OR OTHER PERSON(S) DESIGNATED BY ME: _____

I AUTHORIZE DR LEE MORAND & ASSOCIATES LLC TO PROVIDE ANY AND ALL NECESSARY THERAPY/TREATMENT: _____

I AUTHORIZE MY MEDICAL, AUTO OR WORKER'S COMPENSATION INSURANCE TO MAKE PAYMENT FOR SERVICES RENDERED TO DR LEE MORAND & ASSOCIATES LLC: _____

Signature:_____Date:_____

APPOINTMENT CANCELLATION AND NO SHOW POLICY

PLEASE ACKNOWLEDGE AND INITIAL EACH SECTION:

WE REQUEST NOTIFICATION OF CANCELLATION OF NO LESS THAN 24 HOURS IN ADVANCE OF YOUR SCHEDULED APPOINTMENT: _____

FAILURE TO GIVE AT LEAST A 24-HOUR NOTIFICATION WILL RESULT IN YOU BEING CHARGED A FEE OF **$110**. INSURANCE COMPANIES WILL NOT PAY FOR THIS CHARGE IN THE EVENT YOU MISS AN APPOINTMENT: _____

NO FURTHER APPOINTMENTS WILL BE SCHEDULED UNTIL THE FEE IS PAID: _____

IMPORTANT INFORMATION

- TEXT MESSAGE REMINDERS ARE PROVIDED TO ENABLE COMPLIANCE WITH THE 24 HOUR NOTIFICATION POLICY. IF YOU DO NOT RECEIVE A TEXT MESSAGE REMINDER FOR YOUR SCHEDULED APPOINTMENT, PLEASE CALL THE OFFICE AT 717-610-2988 TO VERIFY. _____

- IF YOU ARE IN NEED OF IMMEDIATE ASSISTANCE THAT CANNOT WAIT UNTIL YOUR NEXT SCHEDULED APPOINTMENT, PLEASE CONTACT CRISIS INTERVENTION BY PHONING: 717-763-2222 (24-HOUR CRISIS) (AFTER 5 PM – CALL 911 AND ASK FOR MENTAL HEALTH DELEGATE). _____