

FAMILY PSYCHOLOGY ASSOCIATES, P.C.

1221 Center Point Rd NE, Cedar Rapids IA 52402 Phone: 319-378-1199

**PLEASE PRINT** Date: \_\_\_\_\_

**Patient** Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Preferred name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: \_\_\_\_\_ SS# \_\_\_\_\_ Sex: \_\_\_\_ Birth Date: \_\_\_\_\_

Email: \_\_\_\_\_ Employer: \_\_\_\_\_

**Spouse** Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: \_\_\_\_\_ SS# \_\_\_\_\_ Sex: \_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

When the Patient is a Minor, please fill in the Mothers & Fathers information.

**Mother** Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Father** Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Emergency Contact** Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Send Statement to:** \_\_\_\_ Self

Name: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**Responsible Party for Payment:** \_\_\_\_ Self

Name: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**Medical Doctor:** \_\_\_\_\_ Location: \_\_\_\_\_

Phone: \_\_\_\_\_

**Insurance** Company: \_\_\_\_\_ Policy ID# \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Authorization #: \_\_\_\_\_ Num of Sessions: \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

**EAP (Employee Assistance Program)**

Company: \_\_\_\_\_ Authorization #: \_\_\_\_\_

Num of Sessions: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

I affirm that the above information is true: Signed: \_\_\_\_\_ Date: \_\_\_\_\_



Don Damsteegt, Ph.D.- Licensed Psychologist-Owner

Therapists:

Bruce Gregory, MA – LMHC  
Carla Hughes, MA – LMHC  
Jessica Malecek, MA – LMFT-t  
Leonarda Decker, MA – LMHC, CADC  
Trey Rosenberger, MA – LMHC-t

**1)---ACKNOWLEDGMENT AND AUTHORIZATION FORM**

I hereby acknowledge that I was given the opportunity to read and to receive a copy of the Notice of Privacy Practices for Family Psychology Associates, P.C.

**2)---AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE CARRIER**

I hereby authorize Family Psychology Associates to furnish my insurance carrier all information required for processing claims. Such information typically includes identifying information (client's name, date of birth, insured's name and address, etc.), diagnosis, prognosis, progress and treatment plan. I understand that I have the right to inspect any materials released to the insurance carrier.

I also authorize my insurance carrier to release any pertinent information regarding coverage, deductible, payments made, or any other information requested to clarify claims to Family Psychology Associates.

I further authorize photocopies to be made of this release and for the insurance company to accept the photocopies.

This authorization shall continue in force and effect until revoked in writing by me.

**3)---AUTHORIZATION TO PAY SUPPLIER**

I hereby authorize payment of Medical Benefits to Family Psychology Associates for services rendered.

**4)---AUTHORIZATION FOR TREATMENT**

I give Family Psychology Associates consent to treat myself or my minor child.

**5)---AUTHORIZATION FOR COLLECTION**

I understand that if I fail to pay, the account can be turned over for collection and that I will be responsible for all costs involved.

**6)---AUTHORIZATION FOR CONTACT & REQUEST FOR APPOINTMENT REMINDERS**

Other than by phone, how may we contact you? This includes, but not limited to; reminders, appointment changes and billing. We may find it necessary to send you billing statements in the mail.

Email: \_\_\_ Voice Mail: \_\_\_ Text: \_\_\_ US Mail: X

Appointment reminder via: (choose one) Text: \_\_\_ Voice Mail: \_\_\_ None: \_\_\_ Ph# \_\_\_\_\_  
*Please be aware, due to the nature of text and voice mail, we cannot guarantee security or confidentiality. You may choose to decline this service at any time.*

**Acknowledgment and agreement of above numbers #1, #2, #3, #4, #5, #6**

X  
\_\_\_\_\_  
Client/Insured Signature/Biological Parent (or Legal Guardian)  
forms/ 03/07/19

\_\_\_\_\_  
Date