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

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) **Date**

forms/ 03/07/19