COMMUNITY PSYCHOLOGICAL CONSULTANTS
11350 N. Meridian Street, Suite 300
Carmel, Indiana 46032
An Association of Independent Health Practitioners
P. (317) 574-1785 Fax: (317) 574-1786

ADULT REGISTRATION FORM

Please print, and answer all questions. Thank you.

Provider: Mary L. Sanders, Ph.D., HSPP ____ Daniel Stauber, M.A., LCSW ____

Date_____ New ____ Change ____

Name _____ Date of Birth _____ Gender _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Please circle your preferred contact method.

Presenting Concerns _____

_____

Marital Status _____ Partner's Name (if appropriate) _____

General Medical Condition_____

Current Medications/Dosage _____

Physician (Name & Telephone #) _____

Previous Counseling _____

Employer _____Occupation _____

Highest Grade Completed _____

Name of contact person in case of an emergency _____

Telephone Number _____ Relationship _____

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Request for Confidential Handling of Health Information

____ Mary L. Sanders, Ph.D., HSPP ____ Daniel Stauber, M.A., LCSW

I, _____,
Client Name

give permission to the above provider to contact me or to otherwise transmit confidential health information in the following way(s). Please check all that apply and provide the relevant information:

.

____ U.S. Mail _____

____ Email _____

____ Home Telephone _____

____ Business Telephone _____

____ Cellular Phone _____

____ Fax _____

____ Other_____

Please complete the following section only if you want communication regarding your health care information sent to an alternate address (other than your residence).

_____
Street Address City State Zip code

Referring physician/other: _____

Phone: _____ Fax: _____

Address: _____

Do I have permission to contact your physician to coordinate care? Yes_____ No_____

_____
Signature of Patient/Legal Guardian Date

PAYMENT FOR SERVICES RENDERED

Dr. Sanders does not directly bill insurance for her services. She will, at your request, provide you with a superbill that you can submit to your insurance company for possible out-of-network insurance reimbursement.

Mr. Stauber is an in-network provider for some insurance companies. If you are hoping to use insurance, please complete the following:

Client Name/Birthdate: _____

Insured's Name/Birthdate: _____

Primary Insurance: _____ Insured's Employer: _____

Member ID: _____ Group ID: _____

Insurance Phone Number: _____ Effective Dare: _____

ASSIGNMENT OF BENEFITS AND INDIANA MENTAL HEALTH PROFESSIONAL-PATIENT AGREEMENT

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered.

____
Initial

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that if collection proceedings are necessary, I will pay all fees with collecting this bill.

____
Initial

I have received/read the mental health profession-patient services agreement and agree to its terms and also I have received the HIPAA information contained therein.

____
Initial

Payment is due at the time of service unless other arrangements are made. No-show or cancellations made within twenty-four hours of a scheduled appointment may result in an out-of-pocket charge.

_____

Client's Name Date of Birth

_____

Signature of Client/Parent/Guardian Date