

Dr. John Beiter
650 East Big Beaver Road, Suite A
Troy, MI, 48083

New Client Form

NAME: _____ DOB: ____/____/____ SS# ____/____/____

SEX: ___M___F MARITAL STATUS: ___SINGLE___MARRIED___WIDOWED___DIVORCED/SEPARATED

ADDRESS _____
STREET APT# CITY STATE ZIP

HOME PHONE (____) ____ - ____ WORK PHONE: (____) ____ - ____ CELL: (____) ____ - ____

EMAIL ADDRESS _____

EMERGENCY CONTACT: _____ PHONE: (____) ____ - ____

RELATIONSHIP TO PATIENT: ___SPOUSE___PARENT___GRANDPARENT___OTHER: _____

INSURANCE COVERAGE

BLUE CROSS/BLUE SHIELD _____ ID # _____ GROUP# _____

PLEASE COMPLETE ALL QUESTIONS

Briefly state the problems for which you are seeking care: _____

YES NO

Are you currently under another professional's care for psychotherapy? _____

Have you had psychotherapy in the past? _____

If yes, when and with whom? _____

Referral sources appreciate acknowledgment.

Do we have permission to thank referral?

Referral source: _____

Address _____

Phone _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I authorize payment of medical benefits to John Beiter, Ph.D., or any of his representatives on my behalf for services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by an insurance carrier. By signing below, I hereby authorize said assignee to release any information necessary to secure payment.

CONSENT FOR TREATMENT

I consent to psychological evaluation and treatment by Dr. John Beiter, fully licensed psychologist. I understand and accept the policies of Dr. John Beiter. I understand that I may discuss my treatment with him and may withdraw my consent if I so desire. I further understand that no guarantees have been made to me about the outcome of this care.

My signature indicates that I have reviewed and truthfully responded to the information requested on this form. I have read and understand the above assignment of benefits and consent for treatment. I agree to adhere to them until further written notice.

Signature

date

NOTE: YOUR SIGNATURE REQUIRED