

# Brian S Hissom & Associates, PLLC

Please Print, Complete and Bring With You To Your First Appointment

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell Phone \_\_\_\_\_

Who Referred You To Our Office?

Other Phone \_\_\_\_\_

Physician \_\_\_\_\_

Occupation \_\_\_\_\_

Nurse \_\_\_\_\_

If Student, What Grade? \_\_\_\_\_

Practice Name \_\_\_\_\_

If Student, What School? \_\_\_\_\_

Yellow Page Ad

Our Webpage

Friend/Family \_\_\_\_\_

Employee Assistance Program

Newspaper Ad

Other \_\_\_\_\_

If Client Is Under 18 Years Old:

Parents or Legal Guardians \_\_\_\_\_

Address (if different) \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Brief Description of Problem For Which You Are Seeking Help

Current Medical Problems \_\_\_\_\_

Current medications \_\_\_\_\_

If you have received counseling, psychological evaluation or psychiatric treatment before, please describe the problem that you were having.

And What Was That Therapist or Doctor's Name \_\_\_\_\_

Who Lives In Your House With You?

Name

Relationship

Age

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To File Insurance, we need to following information on the policy holder:

Name \_\_\_\_\_ SS# \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ Marital status of policy holder \_\_\_\_\_ Employed full or part time? \_\_\_\_\_

**FOR OFFICE USE ONLY**

# **CLIENT RESPONSIBILITY**

## **24 HOUR CANCELLATION POLICY**

If you are unable to keep an appointment, a minimum of 24 hours advance notice is required. Without such notice, it is not possible for another client to be seen at that time and you may be charged for that appointment. The only exceptions will be emergency situations. We appreciate your understanding.

## **FEES AND INSURANCE**

Payment for professional services are expected at the time of each appointment unless you have made other arrangements with our office staff. Some insurance companies will not pay our office directly and you may be asked to pay fees and then have your insurance company will reimburse you. Some insurance companies will not pay for our services at all and you will be expected to pay in full, at the time of service.

## **STATEMENT OF CLIENT RESPONSIBILITY**

I understand that I am responsible for ALL charges incurred while receiving services through Brian S. Hissom & Associates, PLLC and will pay at the time of service unless otherwise agreed upon.

Initial \_\_\_\_\_

I have read the 24 hour cancellation policy.

Initial \_\_\_\_\_

I authorize the release of information necessary for processing any insurance claim. I also authorize the release of information should it become necessary to take action to collect overdue accounts.

Initial \_\_\_\_\_

All information included in this questionnaire is true and accurate to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_