

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 _____