Sarene Wallick, LCSW, CCH

CLIENT FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Other

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Policyholder's name:	S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to policyholder:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Policyholder's name:	Group no.:	Policy no.:

Patient's relationship to policyholder:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize Sarene Wallick, LCSW, CCH to perform the necessary treatment/procedure(s) along with the expected benefits, risks or alternative methods of treatment. I understand that I am financially responsible for any balance. I also authorize Sarene Wallick, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Office Policies

1. Payment is due when services are rendered.
2. A client must cancel any appointment that they cannot keep at least 24 hours prior to appointment time. Any appointment not cancelled within 24 hours of the appointment time will be charged full cost of appointment. This charge is not billable to your insurance company. Therefore, the client will be responsible for the full fee.
3. If a patient has met any one of the following criteria listed below they will be discharged from the practice with no exceptions:
   -If a client has two consecutive no show appointments
   -If a client has two consecutive cancellations without giving 24 hours notice
4. It is the client/guardian's responsibility to comply with the therapist's recommended treatment plan.

I have read and agree to the above office polices:

Date:	
Client name (print):	Client or Guardian Signature:

Consent to Treatment

I the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above.

Non-Voluntary Discharge from Treatment: A client may be terminated from this practice non-voluntarily if a. the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the practice, and or b. the client refuses to comply with stipulated program rules, or does not make payments in a timely manner. The client will be notified of the non-voluntary discharge by letter.
Client Notice of Confidentiality: the confidentiality of patient records maintained by the practice is protected by Federal and/or State law and regulations. Generally, the practice may not say to a person outside the practice that a patient attends the program or disclose any information about the patient unless:

1. The patient consents in writing,
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency, or in event of suicidal or homicidal ideation, or to qualified personnel for research, audit, or program evaluation.
4. Suspicion of child, elder or disabled adult abuse, neglect or exploitation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Violations may be reported to appropriate authorities. Federal and state law do not protect any information about a crime committed by a patient either at the practice, against any person who works for the practice or about to commit such a crime. Federal law and regulations do not protect any information about suspected child or vulnerable adult abuse or neglect, or exploitation from being reported under federal and or state law to appropriate state or local authorities, health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the practice's duty to warn any potential victim, when a significant threat has been made. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above stated policies and agreements:

Date:	
Client name (print):	Client or Guardian Signature:

Release of Information Consent:

I, _____ authorize Sarene Wallick to: **Send** or **Receive** (please circle) information pertinent to my treatment:

To: _____ From: _____

Name:	Address:
Signature:	
Date:	