

AMBER HARRIS, MS, LCMFT
316-789-8511

Date

Patient Information:

Patient Name _____ Date of Birth _____
Patient social security number _____ Sex M F
Address _____ city/state/zipcode _____
Cell Phone: _____ Marital Status Married Single Other
Parent Names (if patient is a minor) _____
Parent Address (if different from minor's) _____
Parent Phone (if different from minor's) _____

Emergency Contact:

Name _____ Phone _____
Address _____ city/state/zipcode _____
Relationship with patient: Spouse Parent Child Sibling Friend
 Other

Referred By:

Name _____ Address _____
I give my permission for my therapist to thank this person. Yes No

Insurance:

Policyholder Name _____ Policyholder Date of Birth _____
Policyholder Place of Employment _____
Insurance Company Name _____
Group Number _____ Subscriber ID Number _____

Do you have other insurance No Yes

Insurance Company Name and member ID# _____

_____ Initial stating that you acknowledge and agree to pay the \$40.00 no show fee if you do not contact your therapist to cancel your appointment prior to your scheduled date and time.

Primary Care Physician or Psychiatrist:

Under Kansas law, your therapist is required to consult your primary care physician or psychiatrist to determine if there is any medical condition or medication that is contributing to your presenting symptoms, and to coordinate delivery of healthcare services.

Name of doctor: _____ Phone _____

Name of Clinic: _____

To waive the required consultation with your primary care physician or psychiatrist, sign here _____
(If you do not sign the blank you are granting permission for your therapist to both secure information from your physician or psychiatrist and release pertinent therapy information to them to coordinate your care.)

Please list all medications you are currently taking:

Signature of person completing this form _____ Date _____

Relationship to patient _____

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Therapist signature _____ Date _____