AMBER HARRIS, MS, LCMFT
316-789-8511

Date _____

Patient Information:
Patient Name _____Date of Birth_____
Marital Status _____Married _____Single _____Other Sex _____M _____F
Address _____city/state/zipcode_____
Cell Phone: _____ I give my permission to be called at this number ___Y___N
Work Phone: _____ I give my permission to be called at this number ___Y___N
Email Address: _____
Parent Names (if patient is a minor) _____
Parent Address & 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

_____**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_____

Therapist signature_____Date_____