**Comprehensive Counseling Connections**

## Patient information

Patient's name: ____________________________________________________

Email: _______________________ DOB: _________________

Address: _________________________________________________________________

City: _________________________ State: ______ Zip Code: _________________________

Telephone (Home): _______________________ Consent to leave voice messages? Y or N
(Work): ______________________Consent to leave voice messages? Y or N
(Cellular): ______________________Consent to send appointment reminders via text? Y or N
Consent to leave voice messages? Y or N

How did you hear about us, or by whom were you referred? ________________________

Emergency Contact Name: ___________________________________

Phone Number: ___________________________________

## Insurance Information

(Please complete section below*)

*Name of Primary Care Physician: _______________________Phone #: _______________________

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*Insurance company: ___________________________ *ID #: __________________________*Co-Pay:________

***Do you have a deductible? Y/N (Please circle one) *If Yes, has your deductible been met? Y/N**

*Subscriber's name: ______________________________ *DOB: ___________________________

*Relation to subscriber: _________________________

*Please indicate if you have obtained mental health services outside of Comprehensive Counseling Connections under the health insurance plan you will be using today. ☐Yes ☐No If yes, please indicate the number of visits since January 1st of this year. ______

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*Do you have a secondary insurance? Y/N (Please circle one) (* Is Yes, please fill out section below.)
*Insurance company: __________________________*ID #: ________________________

*Subscriber's name: ___________________________*DOB_________________________

*A. I give my consent for Comprehensive Counseling Connections and its professional staff to deliver psychological services to me, or my children.*
*B. I authorize Comprehensive Counseling Connections to release information to my insurance company as necessary to obtain reimbursement for psychological services provided.*
*C. I understand that I have been given an opportunity to read the patient bill of rights; which is hanging on the waiting room wall as per New Hampshire state statute.*

Signature: ___________________________________________________ Date: ______________

(Individual/Parent/Legal Guardian) Optional: I would like to authorize another individual of family member to call on my behalf to schedule or reschedule appointments or address billing questions or issue for me. I authorize CCC to release information to: ___________________________________________________, as minimally necessary for the task of appointment scheduling. This release will be in effect unless otherwise cancelled in writing.

Signature: ___________________________________________________ Date: _______________