Robert Hawkes, LMHC **Today's Date: _____**

NEW PATIENT INFORMATION

PATIENT INFORMATION

Patient Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street Name and #) (City) (Zip code)

Home Phone: (_____)_____ Date of Birth: _____

Marital Status: _____ Sex: □ Male □ Female □ Other

PCP Name: _____ PCP Phone: _____

Emergency Contact: _____Relationship to you: _____Phone:_____

INSURANCE INFORMATION

Who is responsible for co-pays, deductibles, non-covered services and other balances: (please check only one)

□ Patient □ Other

Patient's Relationship to Guarantor/Policy Holder: □ Self □ Spouse □ Child □ Other

Policy Holder's Name (if other than self)_____
(Last) (First) (Middle Initial)

Name of Insurance: _____ Policy ID Number: _____

Phone number on back of card: _____Policy Holder's Date of Birth: _____

If your insurance requires you to have an authorization/referral, have you requested this from your PCP: YES NO

Do you have a second insurance where claims should be submitted? YES NO

If yes, what is the name of the insurance: _____Policy ID #:_____

Phone number on back of card: _____Policy holder's name:_____DOB_____

Their relationship to you: □ spouse □ other: _____

In consideration of the provision of services to the above named patient rendered by Robert Hawkes, LMHC I agree to be obligated to pay any remaining balance due not covered by my/patient's insurance carrier(s). I also agree to be obligated to pay any fees for missed appointments and/or canceled appointments with less than 24 hour notice, as these charges are not billable to my insurance carrier. In addition, I authorize Robert Hawkes, LMHC to release to parties responsible for payment of my/patient's mental health service bill(s) such information as may be necessary for the completion of financial obligation; this includes my billing office. All such transactions will be undertaken under conditions of confidentiality.

_____ _____

(Patient/Guardian Signature) (Date)