Hope's Place
Where Hope Inspires Healing

654 N. Woodchuck, Suite G, Wichita, KS 67212
316.217.5982
Fax: 620.326.6547

PATIENT INFORMATION Form

Date of call: _____ Referred By: _____ Intake Date: _____

Name: _____Gender: _____DOB: _____

Address: _____

Phone: Home: _____ Cell/Other: _____ Text: Y N
Email: _____

Occupation/School Info: _____

Cultural/Spiritual/Religious Background: _____

Veteran: Y N Branch: _____ Marital Status: _____

Spouse's Name: _____ Children: _____

Parent/Guardian/DPOA:
Name: _____

Address: _____

Phone: Home: _____ Cell/Other: _____

Emergency Contact:
Name: _____Relationahip: _____

Address: _____

Phone: Home: _____ Cell/Other: _____

Physician Information:
Primary Care Physician: _____

Address: _____ Phone: _____

Other Health Provider Currently Seen: _____

Address: _____ Phone: _____

Medications: _____
_____

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Insurance Information

Primary Insurance Co: _____

Address: _____

Insurance ID# _____ Group # _____ Eff. Date: _____

Name of Policy Holder: _____

Policy Holder DOB: _____ Relationship to Insured: _____

Employer: _____

Secondary Insurance Co: _____

Address: _____

Insurance ID# _____ Group # _____ Eff. Date: _____

Name of Policy Holder: _____ SSN: _____

Policy Holder DOB: _____ Relationship to Insured: _____

Employer: _____

CLAIMS AUTHORIZATION:

I AUTHORIZE LINDA YEAROUT, LCMFT, TO RELEASE ANY INFORMATION NECESSARY THAT IS REQUIRED FOR THE PROCESSING OF INSURANCE CLAIMS, INCLUDING, BUT NOT LIMITED TO: DIAGNOSIS, TREATMENT PLAN, PROGRESS IN TREATMENT, DATES OF SERVICE, TREATMENT MODALITY, MEDICAL NECESSITY STATEMENTS. I AUTHORIZE PAYMENT SENT DIRECTLY TO:

Hope's Place
Linda Yearout, LCMFT
PO Box 771
Wellington, KS 67152

I AFFIRM THAT ALL THE ABOVE INFORMATION IS ACCURATE. I AGREE TO ASSUME RESPONSIBILITY FOR THE COSTS OF MY TREATMENT WHICH ARE NOT COVERED BY INSURANCE OR OTHER THIRD PARTIES, INCLUDING NON-COVERED SERVICES, CO-PAYMENTS, AND DEDUCTIBLES. I CONSENT TO TREATMENT BY LINDA YEAROUT, LICENSED CLINICAL MARRIAGE & FAMILY THERAPIST.

Authorized Person's Signature: _____

Date: _____