Hope's Place Where Hope Inspires Healing

300 W. Douglas, Suite #408, Wichita, KS 67202
316.217.5982

PATIENT INFORMATION Form

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

Name: _____Gender: _____DOB: _____
Address: _____
email: _____ Cell/Other: _____ Text: Y N
Occupation/School Info: _____
Cultural/Spiritual/Religious Background: _____
Veteran: Y N Branch: _____ Marital Status: _____
Spouse's Name: _____ Children: _____

Parent/Guardian/DPOA:
Name: _____
Address: _____
Phone: _____ Cell/Other: _____
Emergency Contact:
Name: _____Relationship: _____
Address: _____
Phone: _____ Cell/Other: _____
Physician Information:
Primary Care Physician: _____
Address: _____ Phone: _____
Medical Problems: _____

Other Health Provider Currently Seen: _____
Address: _____ Phone: _____

Coordination of Care Needed: Y N
Medications: _____

_____

Previous Psych Tx: _____
_____
_____

Insurance Information
Primary Insurance Co: _____

Address: _____

Insurance ID# _____ Group # _____

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: _____

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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.

I have received my Client Rights and Responsibilities and Statement of HIPPA practices.

Authorized Person's Signature: _____

Date: _____