GULF COAST PSYCHOTHERAPY CENTER

250 BEAUVOIR ROAD, SUITE 3
BILOXI, MS 39531
228-388-2900

DATE: _____

PATIENT'S NAME: _____

SEX _____ AGE _____ DATE OF BIRTH _____ MARITAL STATUS _____

ADDRESS _____

ZIP _____ HOME PHONE _____ CELL PHONE _____

SOCIAL SECURITY # _____ EMPLOYER _____

PERSON RESPONSIBLE FOR PAYMENT IF NOT PATIENT

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

SOCIAL SECURITY # _____ EMPLOYER _____

INSURANCE CO. _____ ID# _____ GRP# _____

IF PATIENT IS A MINOR PLEASE COMPLETE THIS SECTION:

MOTHER'S NAME _____

FATHER'S NAME _____

NAME OF FAMILY PHYSICIAN _____

WHOM MAY WE THANK FOR THIS REFERRAL _____

BILLING AND INSURANCE POLICY:

I authorize the release of information to my insurance company.

I understand I am responsible for the full amount of my bill for services provided.

I understand there is a $40.00 fee for returned checks.

I understand any unpaid balance over 60 days will be charged interest.

I understand any bill sent to collections will be assessed a $25.00 fee added to your balance.

I understand that the 24 hour cancellation policy requires you to cancel your appointment in advance and this includes weekends. This is necessary to avoid being charged full fee.

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INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

NAME:_____ DATE OF BIRTH:_____

I understand that as a patient at Gulf Coast Psychotherapy I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and through discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several sessions.

I understand that all information shared with the clinicians at Gulf Coast Psychotherapy is confidential and no information will be released without my consent. During the course of treatment, it may be necessary for my therapist to communicate with the physician at Gulf Coast Psychotherapy. A written authorization will be requested prior to any discussion with Gulf Coast Psychotherapy therapists. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by lay to comply with such requests.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

If I have any questions regarding this consent form or about the services offered at Gulf Coast Psychotherapy, I may discuss them with my therapist and/or physician I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Gulf Coast Psychotherapy. I understand that I may stop treatment at any time.

Therapy appointments typically last for 50 minutes. A minimum of 24 hours notice is required to cancel an appointment. There will be a charge for last minute cancellations or no show appointments. Insurance is filed as a courtesy and any deductibles and copays are due at time of service. Any bill not paid within 30 days of notification will be sent to an outside collection agency and additional charges will be added.

Gulf Coast Psychotherapy has a 24 hour answering service for emergencies. Your call will be forwarded to your therapist or physician when possible. If they are not available, the therapist on call will respond. During regular office hours, therapists will return calls at the end of the business day.

Your signature indicates you have read and acknowledge the agreement. Any questions about this agreement, feel free to ask your therapist for clarification.

Signature_____ Date_____