

DOUGLAS R. KEENE, PH.D.

Client Name _____ Social Security Number: _____

Address _____ City _____ Zip _____

Home Phone () _____ Mobile Phone () _____ Work Phone () _____
O.K. to leave message (circle for each)? Yes/No Yes/No Yes/No

Email Address _____ Sex M F Age _____ Birthdate _____

Marital Status: Single Married Widowed Separated Divorced Living Together

Employer/School _____ Occupation _____

Work/School Address _____

Whom may we thank for referring you? _____ Highest education (degree/years in school) _____

Notify in case of emergency: _____ Phone _____ Relationship to client: _____

Names, ages, and relationships of other persons living with you: _____

Primary Care Physician _____ Address _____

Phone () _____ Date of most recent visit _____ Date of most recent physical _____

Describe any health problems _____

List all current medications, dosage, length of time taking it _____

List any allergies to food or medication _____

Please list any previous mental health professionals you have seen, city where located, when and for what reason you saw him/her at that time _____

Please describe the reason you are seeking services from Dr. Keene _____

INSURANCE INFORMATION

Responsible Party _____ Relationship to Client _____

Birthdate _____ Social Security # _____

Address (if different than above) _____

Employer _____ Occupation _____ Work Phone _____

Insurance Company Name _____ Insurance Company Telephone Number _____

Group/Contract # _____ Subscriber Insurance Identification # _____



ADDITIONAL INSURANCE INFORMATION

Please complete this section only if client is covered by a secondary insurance policy

Responsible Party _____ Relationship to Client _____

Birthdate _____ Social Security # _____

Address (if different than above) _____

Employer _____ Occupation _____ Work Phone _____

Insurance Company Name _____ Insurance Company Telephone Number _____

Group/Contract # _____ Subscriber Insurance Identification # _____

ASSIGNMENT OF INSURANCE BENEFITS

I certify that I (or my dependent) have insurance coverage through the company (s) listed herein, and assign directly to Douglas R. Keene, Ph.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Douglas R. Keene, Ph.D. or his representatives to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that most insurance companies do not pay for sessions cancelled within 24 hours of the appointment time. I agree to pay full fee for any appointment not cancelled within 24 hours. I agree to pay all attorney's fees and collection expenses should this office need to institute any suit or action to secure the payment of this note. I understand there is a \$30.00 fee for returned checks.

Responsible Party Signature

Relationship to Client

Date Signed

In order to provide you with the most comprehensive service, I request that you authorize me to inform your primary care doctor that I am working with you. Most managed care companies insist that the psychotherapist closely coordinate with the client's doctor. If you have any questions or concerns about this, I welcome your discussing them with me.

I authorize Douglas R. Keene, Ph.D. to release/receive/exchange information regarding my treatment with my primary care physician whose name I listed prior as well as any medical doctors and specialists who are presently treating me. I understand that my records are protected under Federal and State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent the person or program which is to make this disclosure has acted in reliance on it. The authorization shall remain in effect for as long as I am in treatment with Dr. Keene unless I revoke it. Upon revocation of consent, further release of information shall cease immediately. File copy is considered equivalent to the original.

I acknowledge that the information to be released has been explained to me, and this consent is given of my own free will.

Client Signature

Date Signed

Parent, Guardian or Authorized Representative

Witness

PLEASE READ AND SIGN ATTACHED GUIDELINES 