Susan Anderson, LMFT, LCMHC
1800 Elm St.
Manchester, NH 03104
603-571-0577

Date: _____

Client's First Name: _____Last Name : _____MI _____DOB: _____

Address: _____City/Town:_____State: _____ZIP Code: _____

Telephone (HOME): _____(WORK):_____

Name of Spouse/Guardian:_____Phone Number: _____

Address: _____City/Town: _____State: _____ Zip Code: _____

Place of Employment _____

Person Responsible for Payment: _____

Signature of Person Responsible for Payment _____

Emergency Information
In case of emergency, contact:

Name_____Relationship _____Phone_____
Address_____City_____State_____Zip_____

Physician _____Phone_____
Address_____City_____State_____Zip_____

Psychiatrist_____Phone_____
Address_____City_____State_____Zip_____

Current Medications: _____
_____
_____
Allergies_____

Employment Information

Primary Insurance_____Secondary Insurance_____

Phone_____Phone_____

Contract/ID #_____Contract/ID #_____

Group/Account #_____Group/ Account #_____

Subscriber_____Subscriber_____

Subscribers Date of Birth_____Subscribers Date of Birth_____

Client's relationship to Subscriber_____Client's relationship to Subscriber___

Provisions: Client pays $_____Deductible amount Amount satisfied: $____

Prior Authorization need: _____
Effective Date: _____Policy Anniversary: _____
Coverage for testing_____Annual limits: _____

Referral Source
How did you hear of my private practice?

_____

++

PLEASE INITIAL THE FOLLOWING STATEMENTS:

- ____Failure to attend your scheduled appointments or cancel with less than 24 hours notice, will result in a $50 fee, which must be paid prior to attending another appointment.
- ____I understand that failure to keep scheduled appointments and/ or participation in treatment may result in suspension or termination of my services.
- ____Payment are expected at the time of rendered services, and no more than 14 days after appointment.
- ____I understand I am responsible for payment if my insurance plan requires a deductible.
- ____I authorize the release of any medical or other information necessary to process this claim and authorize payment of medical benefits for services to Susan Anderson, LMFT, LCMHC. **I understand these services may not be covered or only partially covered by my insurance and that I am responsible for any balance of payment.**
- Confidentiality of information (medical history, demographics and treatment pertaining to clinical treatment) may be shared if :
- You are at risk of committing harm to yourself, someone else or are experiencing a medical emergency.
- Emergency mental health screening and/or hospitalization if necessary.
- There is a risk of danger (abuse or neglect) by you or someone else upon a child or an elder.

Client/Parent or Guardian:_____Date_____