Today's Date: _____________ Doctor's Initials:_______

CLIENT INFORMATION:

Patient's Full Name:	Nickname:	DOB: Age:	Gender: ☐F ☐M	SSN:
Marital Status: Single ☐ Married ☐ Other ☐ ________ Spouse's Name/Phone:		Employed Y☐ N ☐ Employer:__________________________ Student: Y☐ N ☐ Part Time ☐ Full-Time ☐ Other ☐ Grade:____		
Home or Physical Address *(Street, City, State, Zip):*		Mailing Address (St,City,State,Zip): *(if different from home address)*		

Contact Information and Appointment Reminder: (*Please provide ALL contact numbers and PICK ONE REMINDER option)*

☐Home:__________________ ☐Work:__________________ Ext:_____ Cell:__________________ Text:☐ Call:☐ (Cellphone carrier e.g. AT&T)_____________

Email:☐ ☐ None, I will remember my own appointment.

Emergency Contact *(Name/Phone/Relationship):*	Who referred you to our office *(Name/Phone/Address):*

REASON FOR YOUR VISIT:

When did current symptoms appear?_______________________________ First date of similar illness?________________________________

Condition related to employment? ☐Yes (Worker's compensation) ☐No (Another type of insurance)

Condition related to an auto accident? ☐Yes (Auto liability or collision) ☐No (Another type of insurance)

If yes, in what State did accident occur? _________________ Condition related to any accident? ☐Yes ☐No

RESPONSIBLE PARTIES: (***Parents or Legal Guardian; Spouse or Partner of the person signing the fee agreement and consent for treatment)***

Name:____
Birthdate:__________ SSN:_______________________
Contact Number/s:________________________________
Mailing Address:_________________________________
City/State/Zip:___________________________________
Relationship to Client:____________________________
Employed Y☐ N ☐ Employer:______________________

Name:____
Birthdate:________________________ SSN:________________________
Contact Number/s:____
Mailing Address:____
City/State/Zip:____
Relationship to Client:____
Employed Y☐ N ☐ Employer:___________________________________

Note: *For parent/s bringing a minor child: The parent who brings the child in for the appointment is responsible for the payment of copay, co-insurance, and or deductible. Payment is DUE at the time service is rendered.*

CUSTODY INFORMATION: (***If client is a minor, choose one or explain further):***

☐Child lives together with BOTH parents and the court has not been involved in custody rulings or proceedings:

☐Child's parents have JOINT legal custody. The other parent's: Name /Address/ Phone is:__________________________________

☐Responsible party has SOLE custody of the child and child lives with responsible party.

☐Legal Guardian is ____

☐Child resides with____

INSURANCE INFORMATION: ☐Check this box if PRIVATE PAY and please provide alternative payment arrangement (*check one below):*

☐Check ☐Cash ☐CreditCard (*Please fill out the credit card authorization form at the front desk*) ☐Others *(please specify):*________________________

FIRST INSURANCE:	**SECOND INSURANCE**:	**THIRD INSURANCE**:
Insurance Plan Name:___________________	Insurance Plan Name:___________________	Insurance Plan Name:___________________
Subscriber ID#:________________________	Subscriber ID#:_____________ ___________	Subscriber ID#:________________________
Group#:_____________________________	Group#:_____________________________	Group#:_____________________________
Insurance Phone:______________________	Insurance Phone:_______________________	Insurance Phone:______________________
Claims Address:_______________________	Claims Address:________________________	Claims Address:______________________
Policy Holder:________________________	Policy Holder:_________________________	Policy Holder:_______________________
Birthdate:___________________________	Birthdate:___________________________	Birthdate:__________________________
SSN:_______________________________	SSN:_______________________________	SSN:______________________________
Mailing Address:______________________	Mailing Address:______________________	Mailing Address:____________________
City/State/Zip:_______________________	City/State/Zip:_______________________	City/State/Zip:______________________
Phone:_____________________________	Phone:______________________________	Phone:____________________________
Employer:___________________________	Employer:____________________________	Employer:__________________________
Relationship to Client:________________	Relationship to Client:_________________	Relationship to Client:________________

Disclaimer: *Insurance represents a contract between the insurance company and the family. It is the responsibility of the client or his/her family to know their benefits and limits of coverage prior to the appointment. Failure to learn these limits yourself does not relieve you from financial responsibility. If your insurance company requires you to get authorization from them before seeing a therapist and you do not do so, and as a result claims are denied, you are responsible for payment in full for the service/s rendered. If you request, and as a courtesy, we will call and obtain benefits information and or authorization from your insurance company. We are not financially responsible for incorrect benefits information given to our office. The final responsibility for payment is yours for any fees, or portion of fees not covered or not reimbursed by your insurance.*

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS:

I authorize the release of any information by my Psychologist and/or his/her agents necessary to process insurance claims and verify the availability of insurance benefits. I also authorize my Psychologist and/or his/her agents to apply for benefits on my behalf for covered services rendered by her/him. I authorize payment be made directly to her/her. I understand that I am financially responsible to her/him for charges not covered by my insurance or this assignment. I permit a copy of this authorization to be used in place of original. This authorization may be revoked by me at any time in writing.

Date:____________________________ Print Name:__________________________________ Signature:____

Raymond H. McCaffrey, Jr., Ph.D.
Licensed Psychologist

______________________________ DOB:__________________ SSN:__________________
Printed Patient Name

SIGNATURE PAGE

Your signature below indicates that you have read the Informed Consent Form and agree to its terms and conditions. This also serves as an acknowledgment that you have received the HIPAA privacy notice form.

Item 1: (Please complete this if Client is a minor. Otherwise, complete Item B)

By signing this document, I am certifying that I am legally authorized to consent to psychological treatment for the above-named minor patient and agree to the above-mentioned terms of Agreement.

______________________________ ______________________________ ______________________________
Printed Name of Guardian Or Authorized Representative | Signature of Guardian or Authorized Representative | Date | Relationship to Child Patient

Item B: (Please complete if client is over 18 years of Age

______________________________ ______________________________ ______________________________
Printed Patient Name | Signature of Patient | Date

AUTHORIZATION TO RELEASE OR EXCHANGE INFORMATION

When you complete this box, you authorize me to release to or acquire information from another person.

I authorize **Raymond H. McCaffrey, Ph.D**. to: RELEASE TO ☐ or ACQUIRE FROM ☐

Name/Phone/ Address ____
____

the following information____

for the purpose of:____________________________. This consent expires:___________________________________

I understand that my records are protected under state federal statutes regarding confidentiality and may not be disclosed without my written consent except in those situations detailed in the Informed Consent that I have previously signed. I also understand that I may revoke this consent at any time except to the extent that action has already been taken based upon it.

Notice
(63 O.S. Supp. 1992, 1-502.2B)

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED DEFICIENCY SYNDROME (AIDS).

Executed this __________________ day of __________________________ 20_______

______________________________ ____
Signature of Witness | Signature of Client and/or Legal Guardian if Client is minor

______________________________ ____
Signature of Witness | Printed Name Client/Parent or Guardian or Authorized Representative

Note: Two witnesses are required if client signs with an "X"