

Mary Ann Mattingly, MS NCC RPT-S

Licensed Professional Counselor
Certified Clinical Mental Health Counselor
P. O. Box 244234
Anchorage, Alaska 99524
wellbeing@maryannmattingly.com
907 522 2010

Patient Information Sheet

Patient First Name _____

Home phone _____

Last Name _____

Work _____ Fax _____

Address _____

Cell _____

Soc Sec # _____

Age _____ Date of Birth _____

Marital Status _____

Employer/School _____

Email _____
May we send invoices or other communications by
email? Y___ N___

Position/Grade _____

Primary Care Physician _____

How did you hear about me or who referred you? _____

Responsible Party's name and address if patient is a minor:

Parents' names (for minors): _____

INSURANCE INFORMATION:

Insurance (primary) (We file primary insurance only):

Company _____ ID # _____ Group # _____

Authorization # _____

Where do we send claims?

Who is the insured? _____

What is the insured's social security #? _____

Insured's birth date? _____ Marital status of the insured _____

What is the relationship between the insured and the patient? _____

Who is the insured's employer? _____

AUTHORIZATION FOR TREATMENT:

I hereby authorize Mary Ann Mattingly MS, LPC to render any necessary therapeutic treatment or to make an appropriate referral. I also agree to pay all fees at the time of the appointment unless other arrangements have been made. **I understand that, regardless of whether my insurance pays Ms Mattingly for her services, I am responsible for the payment of my account. I also understand that if I do not cancel a scheduled appointment within 24 hours of the scheduled time, I will be responsible for the full fees for that session. I acknowledge receipt of the Fee Schedule and Disclosure Statement with the effective date 07-01-2007.** I will notify Ms. Mattingly of any changes in the patient or insurance information. The treatment program may be discussed with other professionals, and, if that occurs, the client's confidentiality will be maintained. The name and identity of the client will be disclosed only in compliance with the Statutes and Regulations of the Board of Professional Counselors.

You have the right to treatment confidentiality. Information may not be revealed to anyone without written permission from you except when disclosure is required by law, as in the following circumstances: suspicion of child abuse, neglect, or abuse of a senior citizen,; suspicion that the client presents a danger by having a plan to hurt himself or someone else; when disclosure may be required pursuant to legal proceeding; and where your insurance company requires information such as diagnosis, treatment plan, etc. to process claims .Individuals may choose to contact Ms. Mattingly via email, fax or cell phone. In doing so, they agree to the understanding that **cell phone, email, and fax communication are not guaranteed confidential methods of communication and when they converse by cell phone, email, or fax, they are, by choice, relinquishing their rights of confidentiality.**

Emergency procedures: for after hour emergencies call 911, go to the emergency room or call the crisis line at 563-3200

Signature of patient _____ Date _____

Signature of responsible party if patient is a minor

_____ Date _____

FAMILY INFORMATION:

PLEASE LIST IMMEDIATE FAMILY MEMBERS THAT LIVE WITH YOU OR OUTSIDE THE HOME, PLACING AN X BESIDE THOSE THAT LIVE WITH YOU:

<u>NAME</u>	<u>BIRTH DATE /AGE</u>	<u>FAMILY RELATIONSHIP</u>	<u>OCCUPATION</u>
_____	_____ / _____	_____	_____
_____	_____ / _____	_____	_____

_____/_____
_____/_____

OTHER PEOPLE RESIDING WITH THE FAMILY AND THEIR RELATIONSHIP TO THE FAMILY:

HAVE YOU EVER BEEN IN THERAPY BEFORE?

Therapist: _____

Reason: _____

When: _____

MEDICAL INFORMATION:

Doctor's name: _____

Date of last physical exam: _____

Medical issues current or past: _____

Medications currently taking: _____