GROWING EDGES

Individualized therapy for dealing with life challenges

DSM _____
(Office Use Only)

Ilyssa Swartout, Psy. D. **602-548-1444 Office**
18205 N. 51st Avenue **602-548-1446 Fax**
Building 2, Suite 115 **602-463-6854 Voice Mail**
Glendale, AZ 85308

Client Information

Date of First Appointment: _____ Referred by: _____

Personal Information (All areas marked with a * MUST be completed)

***Client Name: _____ Nickname: _____**
First MI Last
***Home Address:**
_____
Street City State Zip
***Client's E-mail Address: _____@_____**
Client's Home Phone #: (_____) _____
Client's Business Phone #: (_____) _____
***Client's Main Cell Phone #: (_____) _____**
Other Important Phone #: (_____) _____ *Type of #? _____
*** Client's Social Security #: _____ -_____ -_____**
*** Client's Date of Birth: _____ /_____ /_____ Age: _____**
*** Client's Gender (circle one): Female Male**
*** Client's Martial Status (circle one): Single Married Other (Other** includes Divorced, Widowed & Domestic Partnerships)
*** Client's *School OR Work Status (circle only one): F/T Student P/T Student OR Employed Not Employed***

Primary Insurance Information (All areas marked with a * MUST be completed)

***Insurance Company Name: _____**
Insurance Company Phone #: (_____) _____
***Subscriber's Name (if different): _____**
***Subscriber's Date of Birth: _____ /_____ /_____ *Relationship to client: _____**
***Subscriber's Employer: _____**
***Subscriber's Insurance ID#: _____**
***Subscriber's Group Policy/ID #: _____**
***Subscriber's Phone # (if different): (_____) _____**
***Subscriber's Address (if different):**
_____
Street City State Zip
Co-Payment Amount (Payment is required at appointment time (Check, Cash or Credit Card): $_____ *(Credit cards accepted only for amounts of $20 or more.)
***Do you have an "Out-of-pocket deductible" for counseling? (Circle one): Yes No**
***Deductible amount to be paid for each session $ _____**
***Does you require a "Pre-Authorization" before counseling begins? (Circle one): Yes No**
Pre-Authorization Code (Provided by subscriber's insurance company):
_____
***Number of sessions allowed per calendar year _____**

- ***PLEASE CALL YOUR INSURACNCE COMPANY IF YOU DO NOT KNOW ANSWERS TO ANY OF THE INSURANCE QUESTIONS.***

Family Information (All areas marked with a * MUST be completed)

Immediate Family Members:
***Spouse's Name: _____ Age: _____**
First MI Last
Spouse's Employer: _____
Spouse's Business Phone #: (_____) _____
***Children/Siblings (First names & ages only):**
_____
_____
_____
_____
***Other Extended Family Members Living With Client:**
Name: _____ *Relationship to client: _____
Name: _____ *Relationship to client: _____

Emergency Contact Information (All areas marked with a * MUST be completed)

***Name: _____ *Relationship to client: _____**
*** Contact Phone #1: (_____) _____**
*** Contact Phone #2: (_____) _____**
***Emergency Address:**
_____
Street City State Zip

Secondary Insurance Information (All areas marked with a * MUST be completed)

***Insurance Company Name: _____**
Insurance Company Phone #: (_____) _____
***Subscriber's Name (if different): _____**
***Subscriber's Date of Birth: _____ /_____ /_____ *Relationship to client: _____**
***Subscriber's Employer: _____**
***Subscriber's Insurance ID#: _____**
***Subscriber's Group Policy/ID #: _____**
***Subscriber's Phone # (if different): (_____) _____**
***Subscriber's Address (if different):**
_____
Street City State Zip

To (re) schedule appointments your therapist will call the numbers listed on page 1.

May therapist leave a message on an answering machine? Yes__ No___
May therapist leave a message with someone at these numbers? Yes__ No___
May therapist leave an email message? Yes__ No___

How did you hear about us? (Please circle)

Insurance Co Friend Client of ours GoodTherapy.org Dex Online

Psychology Today Website Yellow Pages (book)

Google Search Words _____ Which brought you to

_____

Doctor _____
Name

Other Person who referred you _____
Name

***I hereby certify that the subscriber listed in this document has active behavioral health coverage with _____ Insurance Company. My signature below is providing express consent to assign all insurance benefits from this company, in relationship to this treatment, otherwise payable to me, directly to Ilyssa Swartout, Psy. D. I further understand that if the subscriber's behavioral health coverage is denied or terminated during the course of treatment, I am completely responsible for all payments of any services rendered. This includes co-payments and deductibles that are not reimbursed through the subscriber's insurance policy. I hereby authorize Ilyssa Swartout, Psy.D. to release all information necessary to secure the payment of benefits. I authorize the use of the signature below on all insurance submissions, whether manually or electronically.**

_____ Date: _____
***Client (or guardian) signature:**

APPOINTMENT CANCELATION POLICY: Growing Edges LLC requires that cancellations for scheduled appointments be received 24 hours in advance. Unkept or cancelled appointments that do not follow this policy will be charged an unkept appointment fee at the discretion of your therapist. This fee can equal but will not exceed the therapist fee for the time originally scheduled. Insurance companies do not pay for unkept appointment fees and the patient/responsible party is held fully accountable for this charge.

I have read and understand the above stated policy of Growing Edges LLC.

_____ _____
***Signature of Responsible Party (required): Date**