GROWING EDGES

Individualized therapy for dealing with life challenges

DSM _____
(Office Use Only)

Ilyssa Swartout, Psy. D. **602-980-9313 Office**

19580 W. Indian School Rd , Ste 105 #134.

Buckeye, AZ 85396 (mailing address)

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 (choose one): ○ Female ○ Male
* Client's Marital Status (choose one): ○ Single ○ Married ○ Other (Other Includes Divorced, Widowed & Domestic Partnership)
* Client's *School OR Work Status (choose 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): _____ Doe
*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? (Choose one): ○Yes ○No

*Deductible amount to be paid for each session $ _____

*Does you require a "Pre-Authorization" before counseling begins? (Choose one): ○Yes ○No

Pre-Authorization Code (Provided by subscriber's insurance company): _____

*Number of sessions allowed per calendar year _____

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*

➢ ***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*

If you live outside of Arizona, please provide a local mental health emergency phone number in your area:

_____

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? (choose one)

○ *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 _____*

*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 which includes the amount that the insurance company would have paid plus the copay amount.

If you miss or cancel an appointment in less than 24 hours from the time of your scheduled appointment, or arrive for an appointment on the wrong day or time, you will be responsible for paying for that session. If I cancel an appointment in less than 24 hours of your scheduled time, or if I have put you in my schedule at the wrong time, then I will give you a free no show appointment.

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

_____ _____

Signature of Responsible Party (required): Date