Ian Laidlaw LCSW, Psychotherapy

Patient Information Form

Please provide the following information and answer the questions below.
Please note: Information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /____ /____ Age: _____ Gender: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home phone: (___) _____ May I leave a message? □ Yes □ No

Cell/other phone: (___) _____ May I leave a message? □ Yes □ No

Email: _____ May I email you? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication*

Emergency Contact Name & Number: _____

Marital Status: □ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

Employer: _____

Employer's address: _____

Referred by (if any): _____

Name of Insured/Responsible Party (if other than self): _____

Relation to Patient: _____

Social Security Number: _____

Address: _____

Date of Birth:: _____ / ____ / ____

Telephone Contact: (___) _____

Physician Name & Number (if applicable): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No

If yes, please list:

_____

_____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, please list and provide dates:

_____

_____

_____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance with

_____ _____
Name of Insurance Company Member ID

I will pay to Ian Laidlaw, LCSW, all insurance benefits paid to me by my insurance company for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I also understand that should the account remain unpaid for more than 90 days, a 1.5% monthly interest charge will be added, as well as any additional collection fees incurred should the account need to be turned over to a collection agency or small claims court. I hereby authorize the provider and/or associated billing agent to release all information necessary to secure the payment of benefits. My name appears on my insurance records as:

_____

I authorize the use of this signature on all insurance submissions.

Relation to Patient:_____Date:_____ /_____ /_____

CANCELATION POLICY

Cancelled appointments may be rescheduled if time permits. I try to be accommodating.

Up to three weeks of missed sessions are provided annually without charge (i.e. if you are scheduled once per week you can miss three sessions per year without charge). You will be charged for all other missed sessions, without exception. Advance notice is appreciated for any missed sessions. Thank you for understanding.

Please acknowledge having read this by signing below. Thank you.

Signature:_____ Date:_____ /_____ /_____