WELCOME TO OUR OFFICE

Richard H. Stout, MS, LMHC, *Licensed Psychotherapist*

3272 W. Lake Mary Blvd., Suite 1820, Lake Mary, FL 32746
Phone: 407-323-0027 * FAX 407-322-0448

Information about the Patient

First Name _____ ***MI*** _____ ***Last*** _____

Date of Birth _____ / _____ / _____ ***SSN*** _____

Patient is: [MALE - FEMALE] [SINGLE - MARRIED - SEPARATED - DIVORCED - WIDOWED)

Address _____

City _____ *State* _____ *Zip* _____

Hm Phone _____ *Wk Phone* _____ *Cell Phone* _____

Email Address: _____

Where may we contact you and/ or leave a message ?
HOME … Yes / No ***WORK … Yes / No*** ***CELL … Yes / No*** ***Email … Yes / No***

If Patient is a STUDENT, what school and grade _____

What EMPLOYER provides this Insurance coverage ? _____

****** *Emergency Contact Person/Phone Number*
_____

Information about the Insured or Responsible Person *(if Patient is a child or spouse)*

First Name _____ *MI* _____ *Last* _____

Relationship to Patient _____ ***EMPLOYER*** _____

Date of Birth _____ / _____ / _____ ***SSN*** _____

Insurance Company Name _____ *ID Number* _____

Were you given an AUTHORIZATION number ? If so, please write it here _____

RELEASE OF INFORMATION

I authorize release of any information necessary to expedite payment of insurance claims. I understand that I am ultimately responsible for any/all charges, regardless of coverage, and understand that any unpaid charges will be sent to Medical Collections.
I authorize payment of medical benefits to the office of Richard H. Stout., MS, LMHC.

Signed *(Patient, Parent or Guardian)* _____ *Date* _____

CONSENT for PSYCHOTHERAPY TREATMENT and STATEMENT OF UNDERSTANDING

I certify that I have the authority to legally consent to Psychotherapy treatment with Richard H. Stout MS, LMHC, and by my signature below, I am giving this consent. Further, I understand and agree that the first office visit is purely for evaluation purposes, and that the counselor is not obligated in any way to continue to treat me. I hereby give Richard H. Stout permission to perform this evaluation and conduct further treatment as deemed necessary. I understand that I am ultimately responsible for any/all charges, regardless of coverage, and understand that any unpaid charges will be sent to Medical Collections. I agree to give at least 24 hours notice of cancellation of any appointment - Otherwise I understand that I will be billed the FULL charge for the session that was reserved for me.

Signed *(Patient, Parent or Guardian)* _____ *Date* _____