

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