Clint Quisenberry, Ph.D.

Licensed Psychologist

C.Q. PSYCHOLOGICAL

1655 Hudson Street, Suite 5 • Longview, Washington 98632

(503) 747-4646 • (503) 214-8668 Fax

ADULT INFORMATION FORM

Today's Date: _____

Full Legal Name: _____

Name you Prefer to be Called: _____

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

Mailing Address: _____

_____

Home Phone: (____)_____ **Preferred #** ☐ **Can we Leave a Message?** ☐ **Yes** ☐ **No**

Cell Phone: (____)_____ **Preferred #** ☐ **Can we Leave a Message?** ☐ **Yes** ☐ **No**

Work Phone: (____)_____ **Preferred #** ☐ **Can we Leave a Message?** ☐ **Yes** ☐ **No**

E-mail Address: _____

Please note that e-mail is not considered to be a confidential medium of communication

Can we Contact You? ☐ **Yes** ☐ **No**

Employer: _____

Occupation Title: _____

Relationship Status: ☐ **Never Married** ☐ **Married** ☐ **Separated**
☐ **Divorced** ☐ **Domestic Partnership** ☐**Widow/er**

Partner/Spouse's Name: _____

Emergency Contact: _____ **Emergency Phone:** (____)_____

Relationship to Emergency Contact: ☐**Spouse** ☐**Partner** ☐**Friend** ☐**Parent** ☐**Child** ☐**Grandparent**

Emergency E-mail Address: _____

How were you referred to me? _____

Who is your current Primary Care Physician? _____

Do you have a Psychiatrist? If so, who? _____

Major/Chronic Medical Problems:

_____

_____

_____

Please List of all Current Medications and Dosages (or Attach List):

MEDICATION	DOSE

BILLING AND INSURANCE INFORMATION

Person Financially Responsible for Services:

☐Self My Social Security Number: _____-_____-_____

☐Other Name:_____ Relationship: _____

Phone: (____)_____ Their Social Security #: _____-_____-_____

How do you Prefer to Cover your Expenses? ☐Cash ☐ Insurance ☐Employee Assistance

Name of Primary Insurance Carrier: _____

Name of Insurance Subscriber: _____

Subscriber's Employer: _____

Subscriber's Birthdate: ____/____/_____

Policy Number: _____ Group Number: _____

Name of Secondary Insurance Carrier: _____

Name of Insurance Subscriber: _____

Subscriber's Employer: _____

Subscriber's Birthdate: ____/____/_____

Policy Number: _____ Group Number: _____

SIGNATURES

COORDINATION OF CARE WITH OTHER PROVIDERS

I ☐DO or ☐DO NOT give Dr. Quisenberry permission to speak with my primary care physician and/or psychiatrist, as listed in this document, to coordinate my care. If given permission Dr. Quisenberry has the responsibility to communicate to you when he speaks with your provider and the nature of that conversation.

Printed Name: _____

Signature: _____ Date: _____

AGREEMENT FOR PATIENTS WITH INSURANCE

If you use insurance benefits to help cover evaluation and treatment costs, you will need to allow Dr. Quisenberry to communicate with your insurer. Your signature below allows:

1. **Dr. Quisenberry to release basic, confidential information about your, such as the type and dates of service, diagnosis, and any other information required to process your claim.**
2. **Your insurance company to pay benefits directly to Dr. Quisenberry to be applied to your account.**
3. **Dr. Quisenberry to bill your insurance company in the future without you having to sign for this each time.**
4. **I am solely responsible for any deductibles, co-pays, and/or co-insurance as dictated by my insurance company.**

Further, I understand that I am solely responsible for any charges not covered or reimbursed by my insurer. I also understand that this authorization is valid until withdrawn by me in writing, and that I may revoke this release at any time for any future service(s) provided by Dr. Quisenberry.

Printed Name: _____

Signature: _____ Date: _____

OFFICE POLICIES

You should have received a document entitled Informed Consent & Outpatient Services Contract as well as another document called HIPAA Notice of Privacy Practices. Please review this information closely as they clearly discuss what you can expect from therapy as well as your rights and responsibilities. Governmental regulation required that we verify that you received this material. Please print and sign your name below.

> **"I certify that I have received a copy of the "Informed Consent for Treatment & Outpatient Services Contract" and "HIPAA Notice of Privacy Practices" from Dr. Quisenberry."**

Printed Name: _____

Signature: _____ Date: _____