maverick
FAMILY COUNSELING

404 Zena Road, Woodstock, NY, 12498
90 Main Street Phoenicia, NY, 12464
34 Church Street, Margaretville, NY, 12455
(845) 679 8650 www.maverickfamilycounseling.com

Adult Client Information Form

Date:_____

Name:_____ Nickname:_____

Date of Birth / / Gender __M ___F

Marital Status: ____Married ____Single ____Domestic Partner ___Divorced ___Widowed ___Other

Address: _____

City: _____ State: _____ Zip: _____

Phone: **Mobile**	**Home:**	**Work:**
___Preferred Phone	**___Preferred Phone**	**___Preferred Phone**
___Voice Mail OK	**___Voice Mail OK**	**___Voice Mail OK**
___Texting OK	**___Texting OK**	**___Texting OK**

Email: _____

How did you hear about Maverick Family Counseling?:_____

Primary Medical Provider: _____ Contact Number:_____

Psychiatrist/Psychiatric NP: _____Contact Number:_____

Emergency Contact: _____Contact Number:_____

OTHER INFO:

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Payment and Insurance Information

Primary Insurance Company:_____**Insurance ID Number:** _____

Name of Person who holds this insurance _____ **Date of Birth:**_____
PLEASE NOTE: *This name may not be your own, as many people are covered under someone else's insurance – e.g. you spouse, your parent, etc.*

Relationship to Insured: __self __spouse __child __other **Insured Employer/School:** _____

Secondary Insurance Company:_____**Insurance ID Number:** _____

Name of Person who holds this insurance _____ **Date of Birth:**_____
PLEASE NOTE: *This name may not be your own, as many people are covered under someone else's insurance – e.g. you spouse, your parent, etc.*

Relationship to Insured: __self __spouse __child __other **Insured Employer/School:** _____

IF NO INSURANCE, WHO IS RESPONSIBLE FOR PAYMENT?_____

Claims Authorization

Our office will be glad to complete and submit any and all insurance forms, but payment and follow-up are the responsibility of the contract holder.

"I hereby authorize the release of any medical or other information necessary to process this claim. If my coverage is under a Group contract held by an employer, an association, a trust fund, a union, or similar entity, this authorization also permits disclosure to them for the purposes of utilization, review or audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with the insurer, including a reasonable time thereafter, until its final consummation."

Payment

Payment and copayments are due at the time services are rendered. It is the obligation of the client to make payment and not that of the insurance carrier unless otherwise explicitly stated by a provider agreement signed in this office.

Cancellation Policy

Therapy is a commitment between a clinician and a client. When a client begins treatment, he or she is making a commitment to a therapeutic process and also to a specific and reserved time, which the therapist holds for the client. And so, when a cancellation occurs, that missed time delays the therapy, and also represents a missed opportunity for somebody else in need, and/or from our large waiting list. In addition, insurance companies do not reimburse for missed appointments.

Therefore, if you must cancel, please give us at least 24 hours notice, so that we can fill your slot with another client. If you are unable to provide at least 24 hours notice when you cancel, **you will be charged a $70.00 cancellation fee**, unless you are able to reschedule that same week in another available time slot. If your appointment is on a Monday, we ask that you advise your therapist by 5pm the Friday prior. A cancellation will only be accepted by a phone message, not by text or email. We understand that in the course of our lives, there are emergencies, childcare issues, and serious, contagious illness. However, due to the commitments outlined above, we are unable to make any exceptions to this cancellation policy.

I verify that I have read and understood the above statements on Claims Authorization, Payments, and the Cancellation Policy.

Signature of Client or Authorized Person Date Signed