DSM __________
(Office Use Only)

Ilyssa Swartout, Psy. D.
18205 N. 51st Avenue
Building 2, Suite 115
Glendale, AZ 85308

602-548-1444 Office
602-548-1446 Fax
602-463-6854 Voice Mail

Client Information

Date of First Appointment: ____________ Referred by: _______________________

Personal Information **(All areas marked with a * MUST be completed)**

***Client Name: _____________________________________ Nickname: ___________**

First ***MI*** ***Last***

***Home Address: ____**

Street ***City*** ***State*** ***Zip***

***Client's E-mail Address: ____________________@____________**

Client's Home Phone #: (_______) _____________________________

Client's Business Phone #: (_______) ______________________________

***Client's Main Cell Phone #: (_______) ______________________________**

Other Important Phone #: (_______) _____________ *Type of #? ___________

*** Client's Social Security #: ________ -________ -________**

*** Client's Date of Birth: ______ /______ /______ Age: ___________**

*** Client's Gender (circle one): Female Male**

*** Client's Martial Status (circle one): Single Married Other** (**Other** includes Divorced, Widowed & Domestic Partnerships)

*** Client's *School OR Work Status (circle only one): F/T Student P/T Student OR Employed Not Employed***

Primary Insurance Information **(All areas marked with a * MUST be completed)**

***Insurance Company Name: ____________________________________**

Insurance Company Phone #: (_______) ______________________________

***Subscriber's Name (if different): _____________________________________**

***Subscriber's Date of Birth: ______ /______ /______ *Relationship to client: ____________________**

***Subscriber's Employer: ____________________________________**

***Subscriber's Insurance ID#: _____________________________________**

***Subscriber's Group Policy/ID #: _____________________________________**

***Subscriber's Phone # (if different): (_______) ___________________________**

***Subscriber's Address (if different): ____**

Street **City** **State** **Zip**

*Co-Payment Amount (Payment is required at appointment time (Check, Cash or Credit Card): $________ *(Credit cards accepted only for amounts of $20 or more.)*
*Do you have an "Out-of-pocket deductible" for counseling? (Circle one): Yes No
*Deductible amount to be paid for each session $ ___________
*Does you require a "Pre-Authorization" before counseling begins? (Circle one): Yes No
Pre-Authorization Code (Provided by subscriber's insurance company):
____
*Number of sessions allowed per calendar year ______________

- ***PLEASE CALL YOUR INSURACNCE COMPANY IF YOU DO NOT KNOW ANSWERS TO ANY OF THE INSURANCE QUESTIONS.***

Family Information (All areas marked with a * MUST be completed)

Immediate Family Members:
*Spouse's Name: __________________________________ Age: _______
First MI Last
Spouse's Employer: ____________________________________
Spouse's Business Phone #: (______) ____________________________
*Children/Siblings (First names & ages only):
____
____
____
____
*Other Extended Family Members Living With Client:
Name: ________________________ *Relationship to client: ______________
Name: ________________________ *Relationship to client: ______________

Emergency Contact Information (All areas marked with a * MUST be completed)

*Name: __________________________ *Relationship to client: ____________
* Contact Phone #1: (______) _____________________________
* Contact Phone #2: (______) _____________________________
*Emergency Address:
____
Street City State Zip

Secondary Insurance Information (All areas marked with a * MUST be completed)

*Insurance Company Name: ____
Insurance Company Phone #: (______) ________________________________
*Subscriber's Name (if different): _____________________________________
*Subscriber's Date of Birth: _____ /_____ /_____ *Relationship to client: ______
*Subscriber's Employer: ____________________________________
*Subscriber's Insurance ID#: ____________________________________
*Subscriber's Group Policy/ID #: ____________________________________
*Subscriber's Phone # (if different): (______) __________________________
*Subscriber's Address (if different):____

To (re) schedule appointments your therapist will call the numbers listed on page 1.

May therapist leave a message on an answering machine? *Yes__ No___*
May therapist leave a message with someone at these numbers? *Yes__ No___*
May therapist leave an email message? *Yes__ No___*

How did you hear about us? (Please circle)

Insurance Co *Friend* *Client of ours* *GoodTherapy.org* *Dex Online*

Psychology Today Website *Yellow Pages (book)*

Google Search Words ___________________ *Which brought you to* ______________________

Doctor __________________________________
Name

Other Person who referred you ____________________________

***I hereby certify that the subscriber listed in this document has active behavioral health coverage with ___________________________________ Insurance Company. My signature below is providing express consent to assign all insurance benefits from this company, in relationship to this treatment, otherwise payable to me, directly to Ilyssa Swartout, Psy. D. I further understand that if the subscriber's behavioral health coverage is denied or terminated during the course of treatment, I am completely responsible for all payments of any services rendered. This includes co-payments and deductibles that are not reimbursed through the subscriber's insurance policy. I hereby authorize Ilyssa Swartout, Psy.D. to release all information necessary to secure the payment of benefits. I authorize the use of the signature below on all insurance submissions, whether manually or electronically.**

____ **Date:** ______________
***Client (or guardian) signature:**

APPOINTMENT CANCELATION POLICY: Growing Edges LLC requires that cancellations for scheduled appointments be received 24 hours in advance. Unkept or cancelled appointments that do not follow this policy will be charged an unkept appointment fee at the discretion of your therapist. This fee can equal but will not exceed the therapist fee for the time originally scheduled. Insurance companies do not pay for unkept appointment fees and the patient/responsible party is held fully accountable for this charge which includes the amount that the insurance company would have paid plus the copay amount.

At the end of every session you will receive an appointment card with the date and time of your next appointment. Please keep this card in case there is a misunderstanding concerning the date or time of your appointment. If you miss or cancel an appointment in less than 24 hours from the time of your scheduled appointment, or arrive for an appointment on the wrong day or time, you will be responsible for paying for that session. If I cancel an appointment in less than 24 hours of your scheduled time, or if I have put you in my schedule at the wrong time, then your next session is free. This will be verified when you bring in the appointment card you were given.

I have read and understand the above stated policy of Growing Edges LLC.

____ _________________________
Signature of Responsible Party (required): **Date**

I give my permission for Ilyssa Swartout, Psy.D. to charge my credit card, if I cannot be there in person, in the event of:

- A missed appointment ____________ (initials). In accordance with the 24 hour cancellation policy. (See informed consent).
- A teleconference session __________ (initials)
- ___________________________(Collateral) attended session _______ (initials)
- Any amount you are responsible to pay after your insurance pays the amount they are responsible for (i.e.: deductibles, copays, no longer covered under your insurance etc.) ___________ (initials)
- Any unpaid balance of 30 days or more ______ (initials)

Signature of card owner ___________________________________ Date _________

(Print name) ____

CC # ____

Expiration Date _______________________________________

3-digit code ________________

Zip Code ___________________