Columbia Counseling Center
COMPREHENSIVE PSYCHOLOGICAL AND PSYCHIATRIC SERVICES

NEW PATIENT BARIATRIC & SPINAL CORD FORM

PATIENT DEMOGRAPHICS

Last Name: ____________ First Name: ____________ Middle: ____________

Alias/ Nickname: ____________

Social Security #: ____________ Gender: ________ Date of Birth: ____________ Age: ____

Correspondence sent via email: opt in ☐ opt out ☐ Email: ____________

Appointment Reminders by text: opt in ☐ opt out ☐ Cell #: ____________

Permanent / Physical Address (Required)

Street Address: ____________

City: ____________ State: ________ Zip Code: ________ County: ____________

Additional Contact Phone Numbers: Home: ____________ Work: ____________

EMERGENCY CONTACT

Contact Name: ____________ Relationship: ____________

Home: ____________ Work: ____________ Cell / Mobile: ____________

GENERAL INFORMATION

Interpreter Needed? Yes ☐ **No** ☐ Preferred Language: ____________

Marital Status: ____________ Spouse's Name: ____________

Hispanic / Latino Ethnicity? Yes ☐ No ☐ How did you hear about this center: ____________

Check all Race Categories the patient self-identifies as:

☐ American Indian / Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or another Pacific Islander
☐ White / Caucasian
☐ Declined to Answer

EMPLOYMENT / SCHOOL STATUS (Please Check One)

Employed: Full Time ☐ Part Time ☐ Self Employed ☐ Active Military ☐ Retired ☐ Disabled ☐

Occupation: ____________ Employer: ____________

Address: ____________

Student: Full Time ☐ Part Time ☐ Grade: ____ School Name: ____________

Is the school requiring this testing for IEP? ☐ YES* ☐ NO

*If yes, when is the Meeting? ____________

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** GUARANTOR OF ACCOUNT (required if patient is a minor) **

☐ Mother ☐ Father ☐ Legal Guardian ☐ Other ____________________

Last Name: ____________________ First Name: ________________ Middle: ____________

Date of Birth: ________________ Social Security #: ____________________ Gender: __________

Billing Address: ____

City: _________________ State: ____ Zip Code: __________ Contact #: ___________________

PRIMARY CARE PHYSICIAN

Name: ______________________________ Phone Number: ____________________________ ☐

Fax #: _________________________ Location: _______________________________________

REFERRING PHYSICIAN

Physician Name: _________________________ Phone Number: _________________________

Fax #: _________________________ Location: _______________________________________

Reason for Testing: ____

Should this provider receive a copy of your testing report? ☐ YES ☐ NO

Is this provider a **NEUROLOGIST**? ☐ YES* ☐ NO

*If yes, please have them send records over immediately, these will be required to complete your report.

INSURANCE INFORMATION

Primary Insurance: ____

Subscriber's Name: ________________________ Relationship to Patient: ____________________

Date of Birth: _____________ SS#________________ Employer: _________________________

Policy #: _________________________ Group # (if applicable) ____________________________

Secondary Insurance (if applicable): ____

Subscriber's Name: ________________________ Relationship to Patient: ____________________

Date of Birth: _____________ SS# ________________ Employer: ________________________

Policy #: _________________________ Group # (if applicable) ____________________________

SELF PAY / NO INSRUANCE (Only patients without insurance)

☐ I do not have health Insurance / Do not wish to have my health insurance billed. – See self-pay waiver

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OFFICE POLICY AND SIGNED CONSENT OF PRIVACY PRACTICES

I, as the patient, have read and understand of all office policies. I understand that all copays, deductibles and coinsurance payments that are not covered by my insurance are due in full at the time of service. The accepted payment methods are Visa, Mastercard, Discover, Personal Checks and Money Orders. The office will charge a **$28.00 fee** for any **returned check/s.** Past due accounts are subject to a **3% late interest fee** as well as a no reschedule policy until the balance is paid in full. The office requires **24HOUR notice** to break any Testing Sessions, this policy is strictly enforced and will be subject to a **$75.00 late cancelation fee or no-show fee PER HOUR OF TESTING Scheduled** if the patient does not notify the office at all; this fee is not covered by the insurance. The office does provide 24hour phone coverage which will allow you to leave a message to cancel any appointment. **I agree to allow Dr. Sholtis to discuss treatment with my current physician/s listed above to better asses the needs of my Psychological / Neurological Testing.** I understand that my entire testing process may take up to 3-5 months (from start to finish) to complete.

I declare I have listed all medical health insurance plans from which I may allow Columbia Counseling Center to bill on my behalf. I agree that the information supplied on the form is accurate and up to date to the best of my knowledge. Any future changes in the above information, especially those that may affect the processing of my insurance claims, shall be updated with Columbia Counseling Center in a timely manner before any service has been rendered. Any claim/s that comes back from my insurance company that is not covered for any reason/s will be made the patients responsibility. By signing below, I agree to the above office policies and agree to be responsible for 100% of all fees associated with my personal patient account.

I acknowledge that I have received a copy of the Notice of Privacy Practices and I consent to the policies and disclosure of my PHI.

Patient (guarantor) Name: ________________________ Signature: ________________________

Date of Patient Consent: ____________________ Witness (Office Staff) Name: ______________ Date : ________