Create A Healthy Mind
New Client Information Form

Name of Client/Patient: __________________________ Date of Initial Session: ______
Date of Birth: ________Referred by: ____
Home Address: _________________________________ City: _________ ____ State: ______
Zip: ___________ Home phone: ____________________ Work phone: _________________
Emergency phone contact (cell) ___________________________________ ____________
Parent(s) if under 18: ____
School (if student): ______________________________ Year in School: ________________
Primary Teacher (if Elementary School): _____________________ Phone: ____________
Name of Insured: ______________________________ DOB of Insured: _________________
Employment: ______________________________ Occupation: __________________________
ID number of Insured: _________________________ Group#_________________________
Mailing Address of Insured (if different from above):
____
Co-pay: ______________ Deductible: ______________ Co-insurance: ________________
Primary Care Physician: _________________________ Phone: _______________________
Person other than self to call in an emergency: _________________________________
Phone number of emergency contact: ____

<u>General Information Regarding Services</u>:
I am available to schedule appointments between 8:30 am. and 5pm Monday through Friday. We will generally meet for fifty minutes at a time. However the initial evaluation or session can last up to two hours if testing is included. My standard fees are between $150.00-$250.00 for an initial consultation or diagnostic interview, $90.00-$150.00 for a standard fifty-minute therapy session, and $150.00 for one hour of professional supervision. Psychological testing can range between $450.00 up to $5,000.00 depending on the nature and quantity of the tests involved and the amount of family members that need to be evaluated. For testing, all fees must be paid as soon as the data is obtained and before the writing of any written reports. I have a sliding scale for those who need it.

<u>Please Sign Below after reading notice of privacy practices</u>:
I, the undersigned, agree to be financially responsible for the treatment I receive. I may use health insurance to pay for part or all of this treatment in accordance with any contracts that Create A Healthy Mind might have with my insurance company. However, if there is no specified contract in operation, or if the insurance company fails to pay for it's portion of my treatment, I will be responsible for paying my bill in full at the end of each session I attend. I further agree to pay in full for any missed appointments unless I either give 24 hours notice of cancellation, or am unable to attend due to being medically contagious, or having to take care of a person in my care who is seriously ill and needs supervision. Patients are not permitted to use email to cancel or reschedule appointments. Finally, should it be requested in writing, I give Dr. Parks permission to provide diagnostic information to my insurance company. I, the undersigned, have thoroughly read the privacy practices for Create A Healthy Mind as well as the General Information Regarding Services, and agree to their terms.

____________________________________ ____________________________________
Client or Legal Guardian (if under 18) date signed

____________________________________ ____________________________________
Witness Signature date signed