Richard Lee Belsham, Ph.D.

Patient/Client Information Form

Name_____Date of Birth_____

If Under 18, Name of Parent/Guardian_____

Last Four Digits of Social Security #_____

Address _____

City, State, Zip_____

Home Phone_____ Cell Phone_____

Email _____

Please list a phone number where you would like to receive a text or call for appt. reminders:

Text # _____ **or** Phone #_____

Who To Contact In Case Of Emergency_____ (Phone)_____

Referral Source (How did you find us)_____

Informed Consent/HIPPAA Notice

The signing of this section indicates consent of participation in the psychological and/or psychotherapeutic treatments to be provided by Dr. Richard Belsham. It is understood that you have the right to have all of your questions answered as well as to withdraw from participation at any time during the process. I have also been provided a copy of the FL HIPPAA Notice Form.

Authorization of Insurance Payment

I authorize payment directly to Dr. Richard Belsham by any health insurance or health plan benefits payable for the services rendered. I also authorize the release of any medical or other information necessary to process my claim.

I understand that there will be a $50.00 charge for all appointments that are not kept or cancelled within 24 hours of my scheduled appointment. This charge is not covered by insurance and will be billed directly to the patient.

_____ (Date)_____

(Patient or Authorized Person's Signature)

PLEASE PROVIDE INSURANCE CARD(S) TO OFFICE MANAGER