**BRICKEN AND ASSOCIATES, P.C.**
**25810 Oak Ridge Drive**
**The Woodlands, Texas 77380**
**(281) 364-0067 – Fax (281) 364-0712**



# New Patient Private Insurance Intake Form

***These questions will help me get to know you and to insure that I provide you with the appropriate care. Feel free to leave any questions blank that you are uncomfortable with until you talk to me. Thank you.***

**Patient Name: _____ Date of Birth: _____ Age: _____**
**Sex:** M / F **Home Phone: _____ Cell Phone: _____**
**Date of Injury or Onset of Illness: _____**
**Treating Physician: _____ Phone:_____**
**Have you ever seen a Psychologist or Psychiatrist?** Y / N **If Yes, Reason:_____**
**If Yes, Who?_____ Phone:_____ When?_____**
**Education Level: _____ GED / H. S. Diploma:** Y / N **Graduation / GED Date:_____**
**Martial Status *(Select One):*** Select One **Number of Marriages: _____ Years Married: _____**
**Number of Children: ____ Ages:____ ____ ____ ____ ____ ____ ____**
**Are your Parents living? Father:** Y / N **Mother:** Y / N
**Are they still married?** Y / N **If no, how old were you when they divorced? _____**
**Do you have any Brothers?** Y / N **If yes, how many? _____ Good Childhood?** Y / N
**Do you have any Sisters?** Y / N **If yes, how many? _____**
**Have you had Physical Therapy?** Y / N **If so, how long?_____**
**Have you had any surgeries to repair injury?** Y / N
**Are you scheduled for more surgeries?** Y / N
**What type of procedures/therapies have you had? _____**
**_____**
**Medications and how many per day: _____ _____**
**_____ _____ _____ _____**
**Opiod's/Narcotics and how many per day: _____ _____**
**_____ _____ _____ _____**
**Do you smoke cigarettes?** Y / N **If yes, how much? _____**
**Do you drink alcohol?** Y / N **If yes, how much in the past week? _____**
**Do you have a plan to harm yourself or anyone else?** Y / N
**Have you ever had a history of drug addiction?** Y / N
**If yes, what drugs and when did you quit? _____**
**Do you have any other Medical Issues?** Y / N **If yes, what? _____**
**Rate your pain_____ (1-10) 10= worse pain ever experienced, 1-almost no pain**
**Where is your pain? (if any) _____**

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*****Please fill out Employment History*****

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**Current Employment: _____ Phone: _____**
**Address: _____ City: _____State: _____Zip: _____**
**Position: _____ Length of Employment: _____years _____months**
**Previous jobs & how long in each: _____**
**1)_____**
**2)_____**

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**Patient Name: _____**

## Symptom Checklist

**Height:___'___"  Weight: _____lbs  Weight Gain: ____lbs  Weight Loss: ____lbs**

**Number of Hours of Sleep:_____hrs**

**Please check all that apply**

- ☐ **Difficulty Sleeping**
- ☐ **Crying Spells**
- ☐ **Loss of Sex Drive**
- ☐ **Memory Loss**
- ☐ **Temper Outbursts**
- ☐ **Frustration**
- ☐ **Rapid Heart Beat**
- ☐ **Difficulty in Catching Your Breath**
- ☐ **Light Headed**
- ☐ **Sense of Impending Doom**
- ☐ **Nausea**
- ☐ **Loss of Appetite**
- ☐ **Loss of Enjoyment**
- ☐ **Difficulty with Concentration**
- ☐ **Anger**
- ☐ **Panic Attacks**
- ☐ **Stomach Knots**
- ☐ **Tightness in Chest**
- ☐ **Shortness of Breath**
- ☐ **Profuse Sweating**
- ☐ **Nervousness**
- ☐ **Headaches**

**Additional information you would like to share about yourself and your situation:**

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## Patient Information Sheet

Date: _____

Patient Name (First) :_____ (M.I.):___ (Last):_____
DoB: __/__/____ Sex: M / F SSN:____/___/_____ DL#:_____
Address:_____Apt#:_____
City:_____State:_____ Zip Code:_____
Home Phone:(_____)_____ Cell Phone:(_____)_____
Employer:_____Work Phone:(____)_____

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Person completing form:_____ Relationship w/patient:_____
**(If other than Patient)** (Mother/Father/Guardian/Spouse)

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***CASH CASE**: **YES**___ **NO**___*

## Insurance Information

Primary Insured Name: _____Relationship w/ Patient:_____
Insurance Company Name:_____
Address: _____
_____
Insurance Co. Phone:(____)_____Insured Employer:_____
Policy#: _____ Group:_____ Insured SSN #:____/____/_____
DOB:____/____/_____

*If you have a secondary insurance please ask for another form and complete just this section.*

I hereby authorize the release of any medical information necessary to process my insurance claims. I permit a copy of this authorization to be used in place of the original. By signing this form, I am authorizing medical/psychological treatment by Dr. Glenn J. Bricken & Associates. I also authorize payments of medical benefits directly to this doctor for services received in this office, if assigned.

**I give my permission for information and a treatment report to be disclosed to the referring doctor.**

***I understand that I am financially responsible for all fees incurred for services rendered by this doctor, which are not paid by my insurance.***

**Signature:X**_____**Date:**_____

**(This must be signed by the patient, or by their legal guardian if under age, prior to any services being rendered.)**

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## CANCELLATION POLICY

-We look forward to working with you. Our appointment sessions are approximately forty-five (45) minutes long. It is our strict policy to stay on time for all scheduled appointments. Therefore, if at all necessary, your wait time is kept to a minimum. Due to the length of time provided for each appointment, it is critical that we receive twenty-four (24) hours notice for all cancellations. We also request any cancellation for Monday morning appointments be made no later than 3:00pm Friday prior to your appointment. Insurance companies will not pay for "No Shows or Late Cancellations," therefore you will be responsible for the full fee of $125.00 for missed individual appointments and $60.00 for missed group appointments. _____**:INITIAL HERE**

## URGENT CARE

-If you are in crisis and need to contact our providers, we have staff in the office Monday – Friday from 8:00am to 5:00pm. After hours and weekends we have a pager notification system in place via our phone service to accommodate emergencies only. Please listen to the message and pick the appropriate option for the provider you need to contact. The urgent/emergency calls will be returned as quickly as possible. If the urgent care call lasts more than twenty (20) minutes you will be charged for an abbreviated therapy session. If there are multiple calls that accumulate to more than thirty-five (35) minutes you will be charged for a full individual therapy session. _____**:INITIAL HERE**

## CONFIDENTIALITY POLICY

-Limits of confidentiality include suicidal threats, homicidal threats, or any type of physical or sexual abuse of a child. We are mandated by our state licensing board to report any suspicion of child abuse to Child Protective Services (CPS).

- I give my permission for my treating therapist to consult with the counselors and/or doctors at *Bricken and Associates* to insure quality of care. _____**:INITIAL HERE**

## PAYMENT ARRANGEMENTS – DELINQUENT ACCOUNTS

-To avoid any unpaid balance we request you pay each co-payment or co-insurance amount due at the time the services are provided to you. If there are any problems with your insurance carrier we will attempt to notify you and keep you informed of any details, requests for information, or insurance termination notices. Thus we can work together to pursue payment from the insurance carriers to the fullest extent.

-If for any reason your account with us becomes delinquent for more than ninety (90) days, it is our policy to attempt to resolve the matter with you directly. We can make payment arrangements if you are unable to pay in full. Our payment arrangement policy includes a ten (10%) percent interest charge (APR) to carry a balance. This interest charge will be added to accounts monthly.

-If we are unable to resolve the account with you, our policy is to turn over the account to our collection agency. This agency will be given only your name and the charges on the account. Once the account is forwarded, we will no longer be able to make any private arrangements with you.

_____**:INITIAL HERE**

_____ **X**_____

Patient Name (Please print) **Patient Signature**
(If the patient is a minor, then parent or legal guardian's signature is required)

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## TESTING & REPORT AGREEMENT

By signing below I understand that my insurance company may not cover some of the services provided by Bricken & Associates PC. These non-covered services included, but are not limited to, reports and psychological testing for educational purposes, court related requests and IQ testing. If the insurance company does not pay for or certify these services, you will be required to pay for these expenses. Thank you.

Patient Name: **X** _____ (Please print)

Responsible party name: **X** _____ (Please print)

Responsible party signature: **X** _____

Date: _____

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## PF-2000

### Acknowledgement of Receipt of Notice of Privacy Practices

**Bricken & Associates P.C.** reserves the right to modify the privacy practices outlined in the notice.

**I have received a copy of the Notice of Privacy Practices for Bricken & Associates P.C.**

_____
Print Name of Patient

**X** _____
Signature of Patient

**___/___/20___**
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

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Relationship of Patient Representative to Patient