BOIKE
PROFESSIONAL BUILDING
The Counseling Place

Judy Taylor, LCSW-R
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Phone 585 394 1442 ext 309

Patient Information **Today's Date_____**

First Name_____ Middle Initial ____ Last Name_____

Address Line 1 _____

Address Line 2 (Suite, Apt #, PO Box) _____

City _____State _____ ZIP Code _____

Date of Birth _____ SSN # _____

Phone (Home) _____ (Work) _____ (Cell)_____

Is it okay to leave messages at: Home __Yes __ No; Work ___ Yes __ No; Cell __Yes __No

Patient's Sex (choose one) ____ Male ____ Female _____ Transgender Male (F to M)

_____Transgender Female (M to F) _____Other _____ Choose Not to Disclose

Marital Status and Family Information

____Single ____Married (# of years) ____Legally Separated (# of years) _____ Divorced (# of years)

____ Domestic/Life Partner (# of years) Spouse/Partner Name _____

Are there any children in the household? ____ Yes ____ No If yes, please complete…

Name	DOB	School	Grade	Residence

If divorced/separated, who has custody of children? _____

Stepmother's Name (if applicable) _____Stepfather's Name(if applicable)_____

***Complete this section only if the patient is a minor child:**

Mother's Name _____	Father's Name _____
Mother's DOB _____	Father's DOB _____
Mother's SS# _____-____-_____	Father's SS# _____-____-_____
Mother's Address _____	Father's Address _____
City _____State ___ Zip_____	City _____ State ____ Zip_____
Mother's Home Phone _____	Father's Home Phone _____
Mother's Cell Phone _____	Father's Cell Phone _____
Mother's Occupation _____	Father's Occupation _____
Mother's Employer _____	Father's Employer _____
Mother's Work Phone _____	Father's Work Phone _____

Are you employed? ____ Yes ____ No ____ Retired ____Disabled **If yes, please complete the following:*

Occupation _____ Full Time _____ Part Time _____

Employer Name _____

Employer Address _____City _____ State ___ Zip Code _____

Employer's Phone Number _____

Spouse's/Partner's Occupation _____ Employer _____

Are you a student? ____ Yes ____ No **If yes, please complete the following:*

Name of school _____Grade/Major _____

Full time ____ Part Time ____ Teacher's Name (if child is in grades K-6)_____

Primary Care Physician and Health Information

First Name_____ Last Name _____

Address Line 1 _____

Address Line 2 (Suite, PO Box, Building) _____

City_____ State _____ ZIP Code _____

Phone _____

Current Health Issues/Concerns _____

Current Medications _____

Allergie**s** _____

Reaction (i.e. hives, trouble breathing, stomach upset, etc.)_____

Have you ever received counseling before? ____Yes ___ No

If yes, when? _____ With whom? _____

Who referred you to our office? _____

May we share information regarding your treatment with your primary care physician? ___ Yes ___No

*****If yes, a separate consent form will be provided to you for your review and signature. ALL INFORMATION PROVIDED BY YOU IS CONFIDENTIAL AND WILL NOT BE DISCLOSED WTIHOUT YOUR EXPRESS WRITTEN CONSENT, UNLESS OTHERWISE ALLOWED BY LAW.***

Patient Name:_____Date of Birth:_____ Chart #_____

Primary Insurance Information

Name of Insurer _____ Insurer Phone (on back of card)_____

Please select your current plan type:
Excellus:
Blue Cross Blue Shield ____ Blue Choice ____ Simply Blue Plus _____ Blue Choice Medicare Advantage _____ Blue Point ___
Federal Blue Cross Blue Shield _____ Child Health Plus _____Blue Choice Option _____ Essential Plan _____

Fidelis _____ MVP _____ MVP Essential Plan _____Aetna ____ Aetna Community Plan _____ Empire Plan _____ NYSHIP ____
POMCO _____ Cigna ____ MultiPlan ____ Tricare _____

United HealthCare:
United Behavioral Health _____ United HealthCare Community Plan _____

Group Number _____ Subscriber ID # _____Effective Date _____

Subscriber Information
First Name _____ Middle Initial _____ Last Name _____

Subscriber Date of Birth _____

Subscriber Relationship to Patient (circle one): Self Spouse Domestic/Life Partner Parent Other

Secondary Insurance Information

Name of Insurer _____ Insurer Phone (on back of card)_____

Please select your current plan type:
Excellus:
Blue Cross Blue Shield ____ Blue Choice ____ Simply Blue Plus _____ Blue Choice Medicare Advantage _____ Blue Point ___
Federal Blue Cross Blue Shield _____ Child Health Plus _____Blue Choice Option _____ Essential Plan _____

Fidelis _____ MVP _____ MVP Essential Plan _____Aetna ____ Aetna Community Plan _____ Empire Plan _____ NYSHIP ____
POMCO _____ Cigna ____ MultiPlan ____ Tricare _____

United HealthCare:
United Behavioral Health _____ United HealthCare Community Plan _____

Group Number _____ Subscriber ID # _____Effective Date _____

Subscriber Information
First Name _____ Middle Initial _____ Last Name _____

Subscriber Date of Birth _____

Subscriber Relationship to Patient (circle one): Self Spouse Domestic/Life Partner Parent Other

Is This a Medigap Policy? _____Yes _____ No

Please Indicate Plan Letter _____ (A, B, C, D, E, F, etc.)

Emergency Contact Information

First Name _____ Middle Initial ____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (Home) _____ (Work) _____ (Cell) _____

Relationship to patient (circle one): Spouse Domestic/Life Partner Parent Other

Responsible Party Information

First Name _____ Middle Initial _____ Last Name _____

Address Line 1 _____

Address Line 2 (Suite, Apt #, Bldg, PO Box) _____

City _____ State _____ Zip Code _____

Phone (Home) _____ (Work) _____ (Cell)_____

Date of Birth _____ Social Security Number _____-_____- _____

Please be advised we do not get involved with divorce decrees regarding payment of fees for services for minors. The parent or person who brings the child in for appointments is responsible for payment of copays, coinsurance, deductibles or private fees (if uninsured) at the time of service and will have to seek reimbursement from the other parent. A receipt of your payment for services will be provided to you at the time of payment.

I _____ have been provided with a copy of the provider's financial policy regarding payment of this account which includes fees for appointments canceled less than 24 hours of appointment time and failure to show for appointments. I understand that unless prior payment arrangements have been made, there will be a $10.00 billing fee added to my account for any balances not paid at the time of service as outlined in the provider's financial agreement and an outstanding balance charge of 1.5% of the total bill will be charged for each month that the bill remains unpaid.

_____ _____
Signature of Responsible Party Date

_____
Relationship to Patient

_____ _____
Witness Date

Patient Name:_____Date of Birth:_____ Chart #_____

AUTHORIZATION TO BILL INSURANCE

I, _____, hereby give my consent for Judy Taylor, LCSW-R to bill my/my child's insurance carrier for the services rendered to me/my child by the above-named provider. In addition, I agree to pay the provider any deductible, copay, coinsurance, or charges for non-covered services in accordance with my health care plan at the time of service as outlined in the provider's financial policy.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if patient is a minor) Date

ASSIGNMENT OF BENEFIT

I authorize my/my child's insurance carrier to pay medical benefits directly to Judy Taylor, LCSW-R for all eligible services rendered to me/my child in accordance with my health care plan.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if patient is a minor) Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INSURANCE CARRIER

I, _____authorize Judy Taylor, LCSW-R to release necessary medical information to my/my child's insurance carrier and/or to their designated managed care company as required by my/my child's insurance carrier to process my/my child's insurance claims.

I understand that my express consent is required to release any health care information related to testing, diagnosis, and/or treatment for HIV/AIDS virus, sexually transmitted diseases, psychiatric disorders/mental health, or alcohol and/or substance abuse. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

_____ _____
Patient Signature (if >13 years of age) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date