Referred By:_________________ Today's Date: _______________

Amy Camp Ryan, LPC

4168 Juniata, Suite 2, St. Louis, MO 63116
Phone: 314-503-2100, Fax: 314-832-9095
www.amycampryan.com

Client Information

Name:____

Date of Birth: ____________________ Gender: Male/Female

Name of Parent/Guardian: ____

Address:____

Home Phone: __________________________Alternate Phone: ______________________

Parent/Guardian Information

Parent/Guardian Name: ____

Place of Employment: ____

Employment Phone: ____

Medical Information

Have you received therapy, counseling, or treatment in the past? _____ Yes _____ No

Name of Primary Care Physician: ____________________Physician's Phone: ____________

Name of Psychiatrist______________________ Psychiatrist's Phone__________________

List all current medications and reason for prescription:

____
____
____

Insurance Information

Insurance Company: ____
Claims Address: ____
Subscriber ID #: ________________________Group #: ____________________________
Authorization #: ________________________ Number of Visits: ______________________

Co Pay: __________________Deductible: ________________Amt. Met: _______________

X____
Signature of Client/Responsible Party
Co-Pays will be collected at the time of service, Thank You

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Relationship Information of Client

Names of other family/friends that are active in client's life

Name	Birth date/Age	Relationship to Client	At Home	Male	Female

Therapeutic Concerns

Please check any symptoms client has had within the past six months:

____ Change in Appetite

____ Difficulties with Sleep

____ Sleep Too Much

____ Behavior Issues

____ Low Self-esteem

____ Tearful, Crying

____ Hopeless

____ Poor Concentration

____ Low Motivation

____ Isolating Behaviors

____ Anger

____ Depression

____ Anxiety

____ Panic

What would be different if therapy worked for you?

____

____

____

____

____

____

____

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Authorization for the Treatment and Financial Responsibility Consent Form

I, ___________________(client's name), request treatment from Amy Camp Ryan, LPC, 4168 Juniata, Suite 2, St. Louis, MO 63116. I consent to routine diagnostic evaluation, case management and therapy as deemed medically necessary. I understand that Amy Camp Ryan, LPC makes no guarantee to me as to the results of treatment or evaluation.

Utilization Review

In the event the client herein is covered by an insurance agreement, the treatment of said client may be subject to utilization review concerning the said client's care with Amy Camp Ryan, LPC. This is required by the Department of Mental Health funds, health maintenance organizations and/or preferred provider organization.

Financial Responsibility

In consideration of services rendered and to be rendered to the client herein, the undersigned responsible party agrees to pay Amy Camp Ryan, LPC for services rendered to the above named client. A client eligible for services under the Department of Mental Health criteria is not responsible for more than the amount determined by the Department of Mental Health Standard Means Test. Members of health maintenance organizations and/or preferred provider organizations are generally required to comply with certain policies and procedures requiring use of participation providers and compliance with plan requirements fro primary referral, emergency admission, pre-certifications and utilization review. These are conditions to payment benefits by companies, healthy maintenance organizations and /or preferred provider organizations. By signing this from which includes a statement about financial responsibility, I as the client, and/or guarantor acknowledge and agree that I am responsible for payment of billed charges rendered in any case in which payment is denied by the companies, health maintenance organizations and/or preferred provider organizations because of a failure to comply with such coverage requirements or for any other reason.

Acknowledgement of Receipt of Notice of Privacy Practices

X________________ (initials of client or person authorized to sign for client)
I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices: that explains when, where, and why my confidential healthy information may be used or shared. I acknowledge that Amy Camp Ryan, LPC may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Amy Camp Ryan, LPC operations and responsibilities.

The Undersigned Certify That They Have Read The Statement Set Forth Above and Accept The Terms Herein.

Client's Signature ____________________________________ Date ________________
Responsible Party's Signature ____________________________ Date ________________
Relationship to Client __________________________________
Witness ____ Date _________________

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Consent to Use or Disclose Information for The Treatment.
Payment and Health Care Operations.

Client's Name____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PH) from your record in order to provide treatment to you to obtain payment for the services I provide, for further treatment provided, and for other professional activities (known as "health care operations"). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right revise my Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of my Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed fro treatment, payment or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notifications. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it, however, I am permitted to refuse to provide health care services if this consent is not granted or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Signature of client/Responsible Party __________________________________

Date ________________