3812 ROCKING ROBYN RUN
KNIGHTDALE, NC 27545

CLIENT INFORMATION

APPOINTMENT DATE_____TIME_____CHART#_____

LAST NAME_____FIRST_____MI_____

ADDRESS_____CITY_____

STATE_____ZIP CODE_____ HOME PHONE_____CELLPHONE_____

How should we contact you_____May we leave a message at any of your listed numbers_____

EMAIL ADDRESS_____ Can we use to remind you of appointments_____

DATE OF BIRTH_____GENDER_____MARTIAL STATUS_____

****

EMPLOYER OF CLIENT_____CONTACT NUMBER_____
OCCUPATION_____May we contact you at work_____

IF CLIENT IS MINOR, ARE THEY A FULL TIME STUDENT_____YES_____NO

PERSON TO CONTACT IN CASE OF EMERGENCY_____
RELATIONSHIP TO CLIENT_____CONTACT NUMBER (S)_____

PRIMARY CARE PHYSICIAN_____PHONE#_____
PRACTICE OR GROUP NAME_____

CONTINUE TO PAGE 2

Client Name_____DOB_____Chart#_____

TWO PATHS CROSSING, LLC
PAGE 2
CLIENT INFORMATION

RESPONSIBLE PARTY INFORMATION

IS CLIENT UNDER AGE 18? YES_____NO_____

IF YES, MOTHERS/GUARDIANS NAME_____
ADDRESS IF DIFFERENT FROM CLIENT_____
EMAIL ADDRESS IF DIFFERENT FROM CLIENT_____
EMPLOYER_____CONTACT NUMBER_____
MAY WE CONTACT YOU AT WORK_____

IF YES, FATHERS/GUARDIANS NAME_____
ADDRESS IF DIFFERENT FROM CLIENT_____
EMAIL ADDRESS IF DIFFERENT FROM CLIENT_____
EMPLOYER_____CONTACT NUMBER_____
MAY WE CONTACT YOU AT WORK_____

WHO DOES MINOR LIVE WITH_____
RELATIONSHIP(S)_____

IS MINOR ADOPTED_____IF YES, AT WHAT AGE_____

BILLING /INSURANCE INFORMATION

PERSON RESPONSIBLE FOR BILL_____
RELATIONSHIP_____CONTACT NUMBER_____
ADDRESS IF DIFFERENT FROM CLIENT_____
_____

CONTINUE TO PAGE 3

CLIENT NAME_____DOB_____CHART#_____

TWO PATHS CROSSING, LLC
PAGE 3
CLIENT INFORMATION

NAME OF PRIMARY INSURANCE_____
NAME OF POLICY HOLDER_____DOB_____
MEMBER'S ID NUMBER_____GROUP NUMBER_____
EFFECTIVE DATE_____IS PRE-CERTIFICATION REQUIRED_____
CONTACT NUMBER(S) FOR INSURANCE_____

NAME OF SECONDARY INSURANCE _____
NAME OF POLICY HOLDER_____DOB_____

Are you currently seeing another mental health provider: Yes or NO If yes, please provide us with: Provider's Name_____Business Name_____
Contact Information_____

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING YOUR PROVIDER FOR SERVICES RENDERED ON YOUR BEHALF, BUT IN NO WAY IS IT A GUARANTEE OF PAYMENT. PAYMENT IS ULTIMATELY THE RESPONSIBILITY OF THE PATIENT (IF NOT A MINOR) OR THE RESPONSIBLE PARTY OF THE MINOR.

We are happy to file your insurance for you (either in network or out of network) if you pay your copays or your full payment (if out of network) at the time services are rendered. Please be aware that nonpayment, rejections, or denials of claims will become the responsibility of the client or the responsible party of the client.

I OR MY RESPONSIBLE PARTY HAVE READ AND AUTHORIZED THE RELEASE OF ANY MEDICAL RECORDS OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM.

CLIENT'S SIGNATURE (IF NOT MINOR) _____DATE_____
RESPONSIBLE PARTY'S SIGNATURE_____DATE_____
RELATIONSHIP TO CLIENT _____

CONTINUE TO PAGE 4

CLIENT NAME_____DOB_____CHART#_____

TWO PATHS CROSSING, LLC
PAGE 4

CONSENT FOR CARE AND TREATMENT

I hereby consent to outpatient treatment and give permission for the provider to provide the services necessary or advisable in the diagnosis and treatment of myself as the client or the parent/guardian of a minor child. I am aware that the practice of psychotherapy is not an exact science and I acknowledge that no guarantees have been made as to the results of treatment received by my provider.

I consent for my provider to obtain emergency care on my behalf or on the behalf of my minor child in the event something should happen that requires medical intervention.

I understand that I have the right to withhold consent to any treatment (deemed necessary or advisable) by my provider. My signature also acknowledges that I have read and understand this statement.

Client Name (Please Print) _____Date_____

Signature of Client or Parent/Responsible Party_____

Relationship to Client_____Date Signed_____

REVISED 04/14/23