

307.426.4204
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 1816 E. 17th St
 Cheyenne, WY 82001



Client Information Form

PATIENT INFORMATION

First Name _____ Middle _____ Last _____

Preferred Name _____ Date of birth _____

Mailing address _____ City _____ St _____ Zip _____

Physical address _____ City _____ St _____ Zip _____

Mobile phone _____ Accept texts? Yes No Leave voice mail? Yes No

Home phone _____ Leave voice mail? Yes No

Work phone _____ Leave voice mail? Yes No

E-mail _____

Birth Sex _____ Race American Indian or Alaska Native
 Asian
 Black or African American
 Hispanic or Latino
 Native Hawaiian or Other Pacific Islander
 White
 Choose not to disclose

Gender Identity _____

Sexual Orientation _____

Marital Status Married Single Other

Employed Unemployed/Other

Full-Time Student Part-Time Student

EMERGENCY CONTACT INFORMATION & PERMISSIONS

Name _____ Relation to client _____

Contact Type PCP Emergency Contact Guardian Responsible Party for Billing

Mobile Phone _____ Home Phone _____ Work Phone _____

What information may we share with this contact?
 Scheduling Information Diagnosis Substance Abuse Notes
 Billing Information Session Notes Psychological Evaluation

Name _____ Relation to client _____

Contact Type PCP Emergency Contact Guardian Responsible Party for Billing

Mobile Phone _____ Home Phone _____ Work Phone _____

What information may we share with this contact?
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Name _____ Relation to client _____

Contact Type PCP Emergency Contact Guardian Responsible Party for Billing

Mobile Phone _____ Home Phone _____ Work Phone _____

What information may we share with this contact?
 Scheduling Information Diagnosis Substance Abuse Notes
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Client Name _____ DOB _____

PRIMARY CARE PROVIDER

Primary care provider _____ Organization _____
 Phone _____ Would you like us to give feedback or consult with them? Yes No

INSURANCE INFORMATION

SPEAK LIFE is a preferred provider for **Blue Cross Blue Shield, Meritain Health, and Medicaid**. If you have insurance other than these, you must check with your insurance to determine coverage.

Note: Co-pays and deductibles are your responsibility.

Primary Insurance Company _____

Insured Party _____	Relation to Client _____
Member ID _____	Insured Party's Information:
Policy Group _____	Birth Sex _____ DOB _____
Employer/School (As indicated on card) _____	Address _____
_____	City/St/Zip _____
Plan Name _____	Phone Number _____

Secondary Insurance Company _____

Insured Party _____	Relation to Client _____
Member ID _____	Insured Party's Information:
Policy Group _____	Birth Sex _____ DOB _____
Employer/School (As indicated on card) _____	Address _____
_____	City/St/Zip _____
Plan Name _____	Phone Number _____

INSURANCE AND PAYMENT

Please initial and sign

_____ I authorize and direct SPEAK LIFE to submit my Charges to any and all Payers including, without limit, my health benefit plan. I understand that I remain personally responsible for my Charges. Consistent with law or contract, I agree to pay the full amount of my Charges to SPEAK LIFE upon its demand.

Client name (please print) _____

Client signature _____ Date ____ / ____ / ____

Forms will be signed at Intake Session.

Client Full Name _____ DOB _____

OFFICE POLICY STATEMENT

SPEAK LIFE prohibits the use of any tobacco products, drugs, or alcohol on its property or in the building. Weapons are not allowed on the property or in the building. All staff, clients, and visitors are expected to comply with this expectation. Signs indicating this policy are prominently displayed throughout the agency.

We ask that you do not come to any appointment under the influence of substances.

Pregnant women, women with children, and IV drug users are given priority in drug and alcohol treatment.

Emergency or “on call” assistance is limited in this private practice. The 24-hour answering machine will establish contact between the hours of 8:00 a.m. and 10:00 p.m. If, during the course of treatment, the problems seem too big, the signature on this statement is an agreement that every effort will be made on your part to contact your therapist. If you are unable to reach your therapist, contact your physician or the nearest emergency room at a local hospital and explain the situation. Your therapist will work in conjunction with your physician. It is recommended that you have communicable disease screening with your primary care physician if you have been placed at risk due to illegal chemical use and abuse or if you have been exposed to unsafe sex. IV drug users are at risk for STDs and are referred to local clinics for screening of risks.

Cancellations within 24-hour advance notice will be accepted, please make arrangements to reschedule at the earliest opportunity. Late cancellations will be charged a \$65.00 late fee.

Payment for series is expected at the time service is rendered. A complete statement of services and credential information is provided for you.

Please read and initial the following:

_____ **A late payment (bill 30-days overdue) will be assessed an extra \$10 charge per month. If the account is referred to a collection agency or attorney, the undersigned agrees to pay all reasonable fees, costs, and collection expenses.**

_____ **I give permission for my insurance to be billed and insurance payment to be submitted to SPEAK LIFE.**

_____ **I give permission to release necessary information to insurance or to the party making payment.**

_____ **By my attendance and my signature, I am consenting to treatment at SPEAK LIFE.**

_____ **I understand that the cash discount pertains only if I pay at the time of service.**

_____ **I understand that I am responsible for any amount my insurance does not cover.**

_____ **I understand that I am responsible to clear coverage with my insurance.**

_____ **I understand that I may be billed \$25 for phone calls at the discretion of the therapist.**

_____ **I have read and received a copy of the Office Policy Statement.**

_____ **I have read and fully understand SPEAK LIFE’s cancellation policy and will abide by the policy rules.**

_____ **If insurance pays me, I am responsible to submit reimbursement to SPEAK LIFE.**

Client name (please print) _____

Client Signature _____ Date ____ / ____ / ____