moontree ***Confidential Client Information***

Name _____ Preferred pronouns _____

Date of birth _____ Age _____ Today's date _____

Street address _____
Street *City* *State* *Zip*

Mailing address _____
(if different) *Street* *City* *State* *Zip*

Primary phone # _____ Type _____ Okay to leave message? **Y N**

Secondary phone # _____ Type _____ Okay to leave message? **Y N**

Email address (optional) _____

Employment _____ Occupation _____

Emergency contact person _____ Phone _____

How did you hear about Moontree? _____

Current primary physician _____ Clinic _____

Are you currently under the care of a psychiatrist, psychologist, or other mental health counselor or therapist? **Y N** *If so, please list name(s) and phone number(s).*

_____

_____

Other current health care treatment or services? **Y N** *If so, please specify.*

_____

_____

Are you <u>currently</u> taking medications? **Y N** *If so, please specify.*

Prescription medication	*Dosage*	*Purpose*

Are you currently taking non-prescription medications or other remedies? **Y N** *If so, please specify.*

_____

_____

_____

Indicate any current medical problems and any significant past medical history

_____

_____

_____

Do you currently exercise regularly? **Y N** *Type* _____

Do you eat a balanced diet? **Y N** *Comments* _____

Do you drink caffeinated beverages (coffee, tea, soda)? **Y N** *Amounts* _____

Do you drink alcoholic beverages? **Y N** *Type & weekly amounts* _____

Do you currently use tobacco? **Y N** *Type & daily amounts* _____

Do you use other drugs or substances? **Y N** *Type & frequency* _____

What problems or needs do you have currently that bring you to Moontree for support?

Have there been recent major changes in your life (jobs, moves, break-ups, illnesses, deaths, etc.)?

Have you been in therapy/counseling before? **Y N** *If yes, please specify.*

Please indicate psychiatric hospitalizations, alcohol/drug treatment, or other significant mental health treatment.

Is there anything else you think we should know that would help us in working with you?

moontree ***Billing Information***

Name _____ Date of birth _____
First M.I. Last

Address _____
Street City State Zip

Phone # _____ Type _____ Okay to leave message? **Y N**

Sex _____ Email _____

Payment Information: *Pls check which options apply:*

☐ I have insurance benefits to cover services. *Complete information below and sign on back.*

☐ Another party, (e.g. parent, agency) will pay for service. *Complete back of form.*

Primary Insurance Carrier _____

Mailing address _____
For submitting claims

Phone numbers _____ _____

Name of insured person _____ DOB of insured person _____

Relationship to insured person (*circle one*) self spouse child other

Policy/Member # _____ Group # _____

Payer ID # _____

Client status (*circle applicable)*: single married other / employed full-time student

Secondary Insurance Carrier _____

Mailing address _____
For submitting claims

Phone numbers _____ _____

Name of insured person _____ DOB of insured person _____

Relationship to insured person (*circle one*) self spouse child other

Policy/Member # _____ Group # _____

Payer ID # _____

Client status (*circle applicable)*: single married other / employed full-time student

The Party below will pay (*circle one*) in full or portion not covered by carrier(s) above

_____ _____
name *relationship to you*

_____
address *city* *state* *zip*

_____
daytime phone *evening phone*

Billing Communication Preferences:

I would like billing statements sent (check all that apply):

☐ As a text to the following phone number: _____

☐ As an email to the following email address: _____

☐ By US mail to the mailing address listed above

This page of signatures indicates your written consent for Moontree to bill either your insurance carrier(s) or another party or both. Please read the information below carefully and sign and date.

Regarding Insurance

SIGNATURE ON FILE: If you would like Moontree to file claims with your insurance carrier, your signature is required below. Read the statements below before agreeing to sign.

- I authorize use of this signature form (or photocopy of it) on all my insurance submissions.
- I authorize Moontree Psychotherapy Center to release to my insurance company any medical information needed to process my claim. This may include release to an outside billing agent.
- I authorize my therapist and/or billing agent to act as my agent in helping to obtain payment from insurance company.
- I authorize payment directly to Moontree Psychotherapy Center.
- This consent remains valid unless expressly revoked. This consent may be revoked by me at any time, except to the extent that action has already been taken.
- I release Moontree Psychotherapy Center from any legal responsibility or liability that may arise from the act of filing my insurance claim.

_____ _____

your signature *date*

I also understand that I am responsible for any unmet deductibles, co-payments, or unpaid claims. I accept that final responsibility for my bill rests with me.

_____ _____

your signature *date*

Regarding Another Party

If you would like Moontree to bill another party, your signature is required. Read the statement below before agreeing to sign.

I understand that I am permitting Moontree to submit a bill to the party identified on page one to pay for these services in full; or for any unmet deductibles, co-payments, or unpaid claims if insurance claims are filed. However, I accept that the final responsibility for my bill rests with me.

_____ _____

your signature *date*