Beech Tree
Consulting &
Psychological Services

Patient Information

Today's date:

Identification

Patient Legal Name | Date of Birth | Preferred Name

Gender | Preferred Pronoun | Marital Status

Preferred Language | Employment Status

If child or adolescent – Names of parents/legal guardians

Home street address | Apt.

City | State | Zip

Home/evening phone | E-mail

Calls or e-mail will be discreet, but please indicate any restrictions

Would you like appointment reminders? Yes No

If yes, by which method do you prefer: Phone Text E-mail

Referral Source

Who referred you to our practice?

Name | Relationship to you

Beech Tree
Consulting &
Psychological Services

Medical Care

Clinic/doctor's name Phone

Address

If you enter into mental health treatment with one of our providers, may your clinician exchange information with your medical doctor so that he or she can be fully informed and we can coordinate your treatment? (please circle) Yes No

Emergency information

Please provide two emergency contacts. We will contact your secondary emergency contact only when/if your primary person cannot be reached. Your emergency contact may be contacted if you experience a medical or mental health emergency in our office. This person may also be contacted if we learn from you via e-mail, phone, tele-communication, or voicemail that you are experiencing a medical or mental emergency outside of the office.

Primary:

Name Phone Relationship

Secondary:

Name Phone Relationship

Financial Information

We truly appreciate your choosing to come to Beech Tree for psychological services. As part of providing high-quality services, we need to be clear about our financial arrangements. Please see the Services Policy for specific rate and coverage information.

Health Insurance Information

If you wish to use your commercial health insurance to assist with covering the fees associated with your treatment, please fill in the information below. Provide information regarding your primary insurance only as we do not file secondary insurance.

Beech Tree
Consulting &
Psychological Services

Subscriber Information:

Name of subscriber	Date of Birth (subscriber)
Name of Insurance Company	
Identification #	Group #
Plan #	Effective date
Claims address	
Claims Phone	
Patient Name	Relationship to subscriber

Self-Pay Information

If you are choosing to self-pay for your services, please note that payment is due in full at the time of service. We accept most major credit, debit cards, and HSA cards. We are happy to provide you with receipts for your records and/or to obtain HSA reimbursement.

Payment Information

We accept cash, personal check, or credit/debit/most HSA cards.

We provide the option of keeping a copy of your credit/debit card on file so that payment can be automatically collected at each session. Your credit card information is stored in electronic format as a "token" to increase the security of your information.

Beech Tree
Consulting &
Psychological Services

Authorization to Keep Credit/Debit Card Information on File

By providing the information below, I authorize Beech Tree Consulting and Psychological Services (BTCPS) to store my credit/debit card information electronically in token format. I authorize BTCPS to automatically "run" this card for payment of services at each session. I understand that I will be informed of the amount to be collected each session before the card is charged. I also authorize BTCPS to automatically charge this card for late cancel and no show fees as they are incurred unless I expressly request otherwise on the date of the late cancel or no show appointment. Please see the Services Policy for No Show and Late Cancellation fees.

We do not keep hard copies of your credit/debit card on file. If you would like for us to keep this information on file, please provide your clinician or our administrative assistant with your card and we will save it into the electronic system.

Authorization:

_____

Printed Name of card holder Signature authorizing the use of this card

_____

Address of card holder

For Office Use only:

Information entered by: _____

Date of entry: _____

Assigned Clinician: _____