SHANNON WEISE COUNSELING, LLC

2601 N. Front Street, STE 201 Harrisburg, PA 17110	Phone: 717-461-7933 Fax: 717-474-3452

NEW PATIENT INFORMATION FORM

Patient Name:		*Address:*
Birthdate: / /	Gender:	Designated Phone # (for calls and voicemails about scheduling, treatment, insurance, etc…)
	Marital Status:	Alternative Designated Phone #:
Occupation		Employer

EMERGENCY CONTACTS

Name of Emergency Contact:	*Relationship to Patient:*
Address:	*Phone:*
Name of Emergency Contact #2	*Relationship to Patient:*
Address:	*Phone:*

IF PATIENT IS UNDER AGE 18

Name of Mother/Guardian:	*Name of Father/Guardian:*
Address:	*Phone:*
Designated Phone # (for calls and voicemails about scheduling, treatment, insurance, etc…)	Designated Phone # (for calls and voicemails about scheduling, treatment, insurance, etc…)

INSURANCE INFORMATION

Subscriber Name:		*Relationship to Patient:*
Birthdate of Subscriber:	*Gender of Subscriber:*	*Insurance Company*
Patient ID #:		*Group #:*
Address:		*Phone:*
I, the undersigned certify that I (or my dependent) have insurance coverage with the company listed above and assign directly to Shannon Weise Counseling, LLC all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hear by authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.		*Responsible Party Signature:* *Date:*

SELF-PAY/NO INSURANCE

By my signature, I agree to pay the stated fee and understand that payment is due when services are rendered. I agree to give 24 hours notice of any cancellation. If I give less than 24 hours notice or no show for my appointment, I understand I will be charged a fee of $110 for the missed session. This agreement will be reevaluated 1 year from the date of the agreement or sooner if the circumstances warrant.	*Name of Responsible Party:* *Responsible Party Signature:* *Date:* *Agreed amount per session:*