COMMUNITY PSYCHOLOGICAL CONSULTANTS
11350 North Meridian Street, Suite 300
Carmel, Indiana 46032
An Association of Independent Health Practitioners
Phone: (317) 574-1785
Fax: (317) 574-1786

ADULT REGISTRATION FORM

Provider (check one): Mary L. Sanders, Ph.D., HSPP ______ Daniel H. Stauber, M.A., LCSW ______

Full Name _____________________________________ **Preferred Name** ____________________

Age_________________ **Birth Date** _______________**Gender Preference** __________________

Address ____

City _______________________________**State** ______________**Zip Code** _________________

Home Phone ______________ **Work Phone** ______________ **Cell Phone** __________________

Email Address ______________ **(Please circle preferred methods of contact.)**

Why are you seeking treatment? ____

____

____

Marital Status _____________ **Partner Name** (if appropriate) ___________________________

Children's Names and Ages (if you have children) _______________________________________

____

____

Occupation ____________________________ **Employer** ________________________________

Education/Highest Grade Completed __________________

Physician Name, Address, Phone Number

____

Current Medical Issues? ____

____

Current Daily Medications (including dosage/administration) ___________________________

____

____

Request for Confidential Handling of Health Information for:

____ Mary L. Sanders, Ph.D., HSPP ____ Daniel H. Stauber, M.A., LCSW

I, ____,
Client, Guardian, or Responsible Party Name

give permission to the above provider to contact me or to otherwise transmit

confidential health information regarding services for ____________________________.
Client's Name

Please check all that apply and provide the relevant information:
.
____ U.S. Mail
____ Email
____ Home Telephone
____ Business Telephone
____ Cellular Phone
____ Fax
____ Other____

Please complete the following section only if you want communication regarding your health care information sent to an alternate address (other than your residence).

____
Street Address, City, State, Zip Code

Referring physician/other professional: ____
Name

Phone: _________________ Fax: ________________

Do I have permission to contact your physician or referring professional to coordinate care?

Yes_____ No______

Please note: Dr. Sanders does not directly bill insurance for her services. She will, at your request, provide you with a superbill that you can submit to your insurance company for possible out-of-network insurance reimbursement.

Mr. Stauber is an in-network provider for some insurance companies. If you are hoping to use insurance, please complete the following:

Client Name/Birthdate: ____

Insured's Name/Birthdate: ____

Primary Insurance: __________________________ Insured's Employer: ______________________

Member ID: ______________________________ Group ID: ________________________________

Provider Services Phone Number: ________________________Effective Date: ________________

ASSIGNMENT OF BENEFITS AND INDIANA MENTAL HEALTH PROFESSIONAL-PATIENT AGREEMENT

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered. _______ (please initial)

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that if collection proceedings are necessary, I will pay all fees with collecting reimbursement for this bill. _______ (please initial)

I have received/read the mental health profession-patient services agreement and agree to its terms and also I have received the HIPAA information contained therein. _______ (please initial)

Payment is due at the time of service unless other arrangements are made. No-shows or cancellations made within twenty-four hours of a scheduled appointment may result in an out-of-pocket charge.

Name of contact person in case of an emergency ___________________________________

Telephone Number _________________ **Relationship** ______________________________

I have read and understand all of the above:

Client Name (please print full name) ____

Authorized Person's Signature _________________________________ **Date** ___________

Authorized Person's Name and Relationship to Client (please print) ___________________

____