

Hardy & Stephens Counseling Associates, PLLC

11070 183rd Circle NW, Elk River, MN 55330

Phone: 763-633-5111

Fax: 763-633-5112

Client Records Entered
into Procentive _____

PATIENT INFORMATION

Patient Full Name		Date of Birth	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	Employment <input type="checkbox"/> Employed <input type="checkbox"/> FT Student <input type="checkbox"/> PT Student <input type="checkbox"/> Other	
Address		City/State/Zip	
Home Phone	Leave Msg? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell Phone	Leave Msg? <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number (required)		How did you hear about us?	
Emergency Contact Name		Emergency Contact Phone	

RESPONSIBLE PARTY (COMPLETE IF POLICY HOLDER IS SOMEONE OTHER THAN PATIENT)

Billing Full Name	Date of Birth	Relation to Patient <input type="checkbox"/> Self <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other
Billing Address		City/State/Zip
Billing Phone	Leave Msg? <input type="checkbox"/> Yes <input type="checkbox"/> No	E-mail Address

BILLING INFORMATION (COMPLETE IF PATIENT IS UNDER 18 OR COVERED BY GUARDIANS INSURANCE)

Mother's Name	Date of Birth	Social Security # (Required)
Home Address		City/State/Zip
Home Phone	Cell	Employer
Father's Name	Date of Birth	Social Security # (Required)
Home Address		City/State/Zip
Home Phone	Cell	Employer

I clearly understand that I am ultimately responsible for payment to HSCA for any and all services rendered due at the time of the visit. I also understand that if I suspend or terminate my care, any outstanding balance will be immediately due and payable.

Billing Signature	Date
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PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Name of Policy Holder	DOB	Name of Policy Holder	DOB
ID Number OR Policy Holder SS#		ID Number OR Policy Holder SS#	
Group Number	Employer	Group Number	Employer

I authorize HSCA to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to HSCA. I understand that I am responsible for payment for services rendered by HSCA regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by insurance company. I agree to notify HSCA immediately whenever I have changes in my health condition or health plan coverage in the future.

Acknowledgement of Receipt of the Notice of Privacy Practices: Federal regulations require that HSCA obtain proof that patients have received the Notice of Privacy Practices. My signature below indicates only that I have received a copy of HSCA Notice of Privacy Practices, not that I have read it or agree with this its contents.

I give permission to HSCA staff to speak with spouse _____ (name)

I give permission to HSCA staff to speak with parents (guardian) _____ (name)

I give permission to HSCA staff to speak with other _____ (name)

who is my _____ (specify relationship), concerning scheduling and canceling of my appointments.

Signature _____ **Date** _____

As a courtesy to our clients, we routinely make confirmation calls, texts or e-mail 48 hours in advance of each appointment for your convenience. I prefer to receive my confirmation by:

Phone #/Text # _____ Carrier _____

E-mail _____

*I understand if I need to cancel or reschedule my appointment I need to call (763) 633-5111.