Matthew Fleming, LLC

PATIENT INFORMATION (PLEASE PRINT)				
Client Last Name::		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
First:	Middle:			Single / Mar / Div / Sep /Wid
Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security No.:	
Street address:		Phone: ( )		
City:	State	Zip Code:		
E-mail:				
Occupation:	Employer:		Work #:	
Primary Care Physician:	Office #:			

INSURANCE INFORMATION					
(please ignore if you are self-pay)					
Name of primary insurance					
Subscriber's Name	Address (if different from above):			Home phone no.: ( )	
Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $	
Occupation:	Employer:	Employer address:		Work #: ( )	
Is this patient covered by insurance?	❑ Yes	❑ No			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Work phone #:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the counselor. I understand that I am financially responsible for any balance. I also authorize Matthew Fleming, LLC or insurance company to release any information required to process my claims. I give permission for Matthew Fleming of Matthew S Fleming, LLC to discuss my case or send reports to my primary care physician. A 24-hour notice is required to avoid being charged, barring extreme emergency. I acknowledge a NO SHOW ($55.00) or LATE CANCEL ($45.00) charge will be assessed and for which I am responsible.

______________________________ *Patient/Guardian signature*	*Date:* ______________________

Matthew Fleming, LLC

Authorization to Release Personal Health Information
to Family and Friends

In order to comply with patient privacy regulations, including the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations on patient privacy and confidentiality, I hereby authorize the use or disclosure of personal health information about me as described below.

1. I authorize the disclosure of my clinical health information by Matthew S Fleming, M.A., L.P.C.C.-S for the duration of my care.
2. Matthew S Fleming, M.A., L.P.C.C-S may release my personal health information that is described above to the following persons.

Name	***Phone***	***Relationship***

3. The purpose of the authorized disclosure is at my request or that of a personal representative.
4. I may revoke this authorization in writing at any time, except for the information already disclosed.
5. This authorization will expire at the termination of treatment with the provider.
6. I understand that I do not have to sign this form and that provider will not condition the provision of treatment to me on the signing of this authorization.
7. I hereby waive and release Matthew S Fleming, M.A., L.P.C.C.-S from any restrictions imposed by law in disclosing or revealing any treatment record, observation or communication to the above named person(s).

________________________________ ________________________________
Patient Name Signature of patient/guardian or representative

Witness: __________________________ Date: ______________________________

Please note that without a signed consent the provider will not be able to discuss any part of your care with family members, friends, or any other individual in person or by phone. Except in cases of emergency.

I do not authorize the disclosure of any information to family or friends.

________________________________ ____________________________
Patient Name Signature of patient/guardian or representative