15480 Annapolis Rd• Bowie, MD • 20715

info@themodalitiesgroup.com • www.themodalitiesgroup.com

CLIENT DEMOGRAPHIC AND AGREEMENT FOR PAYMENT & FINANCIAL RESPONSIBILITIES

By engaging in services with TMG you are agreeing to assume the full financial responsibility for services offered for all portions that is not covered by your insurance company. It is the patients responsibility to ensure they are aware of what benefits are covered by their insurance company. Annually we review fees and review clients insurance coverage, patients will be notified of any fee increases associated with services. Please complete the following and return prior to your initial session.

(Please upload copies of your Insurance card (front and back), Identification (front and back).

Client's Name:____________________ **Date of Birth:**________ **Age:**________

Address:______________________________

City:____________ **State:**________ **Zip:**________ **County:**________

Home Phone:____________ **Cell Phone:**____________ **Work Phone**: ____________

Email:______________________________

Marital Status: S M D W **Gender**: ____________________

Employer/School:________________ **Occupation/Year in School:**____________

Race: White/Caucasian African-Am. Asian Latino/Hispanic Native Am. Multi-racial Other________

Spirituality: ________________ **Importance to You:**________________

Parent or Guardian (if under 18)________________________

Who Referred You? Name:____________________ Phone:____________

May your therapist acknowledge the referral? Yes No

I would like to be placed on the Care and Counseling mailing list to receive newsletters and other center information.

Emergency Contact: Spouse/Partner/Other: **Name:**________________ **Relationship:**____________

Home Phone:____________ **Cell Phone:**____________ **Work Phone:**____________

Permission to Call: **Yes** **No** **Restrictions?**____________________

Secondary Client's Name:____________________

Date of Birth:________ **Age:**________ **Email:**____________________

Marital Status: S M D W **Gender**: ____________________

Race: White/Caucasian African-Am. Asian Latino/Hispanic Native Am. Multi-racial Other________

Party responsible for payment: Self:________ Other/Relationship:____________________

Please Print Name of Insured

Insurance (The office will need a copy of both sides of your insurance card.)

Primary Insurance:____________________ Phone:____________________

Insured Name:____________________ DOB:__________ SSN #:____________________

ID #:____________________ Group:__________ Employer:____________________

**Authorization # (if required by insurance company):____________________

****If I fail to obtain authorization, I am responsible for payment to TMG for the denied session.**

Secondary Insurance:____________________ Phone:____________________

Insured Name:____________________ DOB:__________ SSN #:____________________

ID #:____________________ Group:__________ Employer:____________________

Authorization # (if required by insurance company) **:____________________

****If I fail to obtain authorization, I am responsible for payment to TMG for the denied session.**

(Please upload copies of your Insurance card (front and back), Identification (front and back).

1. I am responsible for obtaining all authorizations and for all charges not covered. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required and waive confidentiality for this purpose).
2. My therapist may discuss accommodations in special circumstances (i.e. video therapy, phone sessions); it is my responsibility to determine insurance coverage for these sessions or to cover the cost of the service at the agreed-upon rates.
3. I authorize TMG staff to communicate with my insurance company for the purpose of claim verification and authorization for services, including a diagnosis code, and for my insurance carrier to release information regarding my coverage to TMG. I authorize the release of any medical or other information necessary to process this claim.
4. My right to payment for all services are hereby assigned to TMG. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to TMG.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

By signing I indicate that I have been notified of my responsibilities for all fees, co-pay/session rate, late cancellation (<24 hours' notice) and no shows I may be responsible for, and that I agree to pay those promptly.

I have read the above statements and accept the terms.

____________________ ____________________

Client Signature or Authorized Persons Signature **Date/Time** AM or PM (circle one)

____________________ ____________________

Responsible Party Signature **Relationship** **Date/Time** AM or PM (circle one)

15480 Annapolis Rd• Bowie, MD • 20715

info@themodalitiesgroup.com • www.themodalitiesgroup.com

HEALTH HISTORY

1. Name ______________________ Date of Birth ______________________
   Occupation ______________________
   In Case of Emergency Contact ______________________
   Phone Number ______________________ Relationship ______________________
   Children and Ages ______________________
   ____
2. Primary Care Physician ______________________ Phone Number ______________________
3. Serious Medical Illness/Accidents (Identify and give dates) ______________________
   ____
   ____
4. Are you currently on any medications? □ Yes □ No
   If yes, please list ______________________
   Any past medications? (May use back of form) ______________________
5. Surgeries or operations (Identify and give dates)______________________
   ____
6. Any hospitalizations? □ Yes □ No
   If yes, when and for what reason ______________________
7. Have you ever been treated for depression/anxiety? □ Yes □ No
   If yes, by whom? ______________________ □ Internist □ OB/GYN □ Psychiatrist
   Please list any medications prescribed ______________________
8. Have you had any previous counseling? □ Yes □ No
   If yes, with whom and when? ______________________
9. Are you or have you been in the care of a psychiatrist? □ Yes □ No
   If yes, with whom and when?______________________
10. Have you ever been treated for alcohol or drug abuse? □ Yes □ No
    If yes, when and where?______________________
11. Have you been the victim of physical or sexual abuse? □ Yes □ No
12. Do you have suicidal thoughts? □ Yes □ No
13. Have you had a suicidal attempt? □ Yes □ No If yes, when? ______________
14. Do you or have you had an eating disorder? □ Yes □ No
15. Do you have a history of infectious diseases? □ Yes □ No If yes, please describe ____________
    ____
16. Do you have any allergies? □ Yes □ No
    If yes, please describe any adverse reactions ______________________
17. Is there past or present nicotine use? □ Yes □ No

Client Signature: ______________________ **Date:** ______________

Legal Guardian Signature: ______________________ **Date:** ______________