

Client Name: _____ Date: ____ / ____ / 200 ____

Address: _____ Phone: _____

City/St./Zip: _____ Birthdate: _____

Email address: _____

Referred By: _____ Soc. Sec. #: _____

Previous Treatment: _____

What brings you here? (con't on back if desired) _____

Marital Status: _____ Name of Spouse: _____ Soc. Sec. #: _____

Names and Ages of Children: _____

Others in Household: _____

Present Medical Status: _____ Physican: _____

Current Medications/Dosages: _____

Employer: _____ Phone: _____

Address: _____

Position: _____ How Long: _____

Name of Insured: _____ Policy #: _____

Insurance Company: _____ Group #: _____

Address: _____

Credit Card # (optional) _____ Expir. date _____ Security code ____ _

Fee and Release Agreement: I understand that fees are due and payable at the time of service rendered, unless otherwise prearranged. I agree to pay in full for any scheduled appointment for which I FAIL TO APPEAR or DO NOT CANCEL at least 24 hours in advance. I agree to pay for telephone or email contacts of a therapeutic nature per stated fees with Kent Tompkins, LPC. I understand if this account is 90 DAYS PAST DUE it will be turned over to a collection agency unless otherwise prearranged. Kent Tompkins is an individual practitioner and has NO relationship with other practitioners except those disclosed in therapy. I understand that I am responsible for discussing the utilization of any health insurance payment. I authorize the RELEASE OF INFORMATION required to process this and future claims with my health insurance carrier and to the referral source; and I authorize payment of benefits to the service provider.

Signed: _____ Date ____ / ____ / 200 ____

DSM- IV Diagnosis (office use only-if applicable) _____

PH: (970) 626-9877
Cell: 970-216-4667
FX: (970) 626-4171
EM: kent@invisionwellness.com