LINDA HUSSER, LPC

906 C.M. Fagan Drive, Suite A-3 – Hammond, LA 70403

Date_____ Client # _____
Clients Name_____ Cell phone _____
Date of Birth_____Age_____ (Male/Female) SS# _____
Address_____Phone _____
City_____State_____Zip Code _____
Email Address _____
Employer/Name of School: _____
Address_____Phone _____
Education: Last grade Completed_____Year _____
Marital Status: Married____Divorced____Separated____Widowed____How Long____Single_____

Name of Parent, Spouse or Significant Other – Relationship to patient: _____
_____Date of Birth_____ Cell phone _____
Address_____Phone _____
City_____State_____Zip Code _____
Email Address _____
Employer_____Office Phone _____
Address _____
College or Other Training _____

Give Full Name of Children and Their Ages _____
_____
_____

Is Patient Presently Taking Medication? Yes_____No _____
What Type? _____
_____
Name of Doctor_____Phone _____

Please List the Name of Family and/or Friends We May contact In Case of an Emergency:
Name_____Phone _____
Address _____

Problem For Which You Are Seeking Help _____
_____
_____
Have You Had Counseling Before?_____Who? _____
Have you seen a Psychiatrist recently? _____Name of Psychiatrist: _____
Date of last visit: _____Who Referred You? _____

What Church are you attending? _____

*Please Read Carefully
I agree to attend the sessions as scheduled, following the verbal contract as established with the therapist.
I agree to pay_____per session. **I agree to pay $100.00 for any session missed or canceled in which I do not give a 24-hour advance notice of cancellation.**

_____ _____
Client (Guardian if Client is under age 18) Therapist Signature

FEE and INSURANCE COMMITMENT

Fees are discussed at the time the appointment is scheduled or at the initial session. Payment is expected at the time of service. Office visits, letters, reports, telephone conferences or prolonged psychotherapy sessions are charged according to the time involved.

The financial aspects of therapy are part of the contract between us. Insurance may help you to fulfill your financial obligation. The final obligation for payment lies with you, not your insurance company. We will assist you in filing your insurance claims. Unless there is an error on our part, it is the patient's responsibility to deal with the insurance company if payment is denied or incorrect. It is your responsibility to pay for the charges and settle with your insurance company. We will also attempt to verify your coverage on or before the first visit. Please understand that this verification is not a guarantee of what your insurance company will cover as benefits are sometimes misquoted to us. We suggest that you also contact your insurance company to determine your coverage for "outpatient psychotherapy" at the onset of therapy. This will give you a better expectation of possible reimbursement.

We will be happy to file for insurance reimbursement; however, you will need to complete the insurance information portion below. You will also need to sign the "Release of Information" form before any insurance can be filed. If your company requires the use of a special insurance form, please supply this form.

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INSURANCE INFORMATION

Client's Name _____

Policyholder Name _____ *Relationship to Patient* _____

Address _____

Policyholder Date of Birth _____ *SS#* _____

Primary Care Physician _____ *Phone #* _____

Employer _____

Insurance Company Name _____ *Phone #* _____

Plan # _____ *Policy or Group #* _____

I authorize Linda Husser, LPC to release any medical information necessary to process this claim for insurance reimbursement. I authorize payment of medical benefits to Linda Husser, LPC for the counseling services provided. I understand that I am responsible for any fees that my insurance company refuses to pay.

Signature _____ *Date* _____

Person responsible for all charges not covered by Insurance. *This includes any fees for missed/canceled appointments in which I do not give 24-hour advance notice.*

Name _____

Address _____ *Phone #* _____

_____ *Relationship to Pt.* _____

Driver's License # _____ *SS#* _____

Signature _____ *Date* _____

I agree to pay $100.00 for any session missed or canceled in which I do not give a 24-hour advance notice of cancellation.

Please note: There is a $35.00 charge for each check that is returned for NSF. After the second check that has been returned for NSF, cash payments are required.

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I have read the above information and agree to the policies of Linda Husser, LPC.

_____

Signature of Client (Guardian if Client is under age 18) Date

Client: _____ **Client Acct. #:** _____

FAMILY HISTORY: *If you or anyone in your family has had any of the illnesses listed below, please put a check in the box and indicate their relationship to you on the line next to the illness.*

- ☐ Allergies or Asthma _____
- ☐ Anemia _____
- ☐ Blood Clotting Problems _____
- ☐ Diabetes _____
- ☐ Cancer or Tumor _____
- ☐ Epilepsy _____
- ☐ Glaucoma _____
- ☐ Genetic Disease _____
- ☐ Alcoholism _____
- ☐ Kidney or Bladder Trouble _____
- ☐ Stomach/Duodenal Ulcer _____
- ☐ Nervous Breakdown _____
- ☐ Rheumatism or Arthritis _____
- ☐ High Blood Pressure _____
- ☐ Heart Disease _____

YOUR HEALTH HISTORY:

Additional Illnesses or Problems: Mark an X in the box next to any of the following that you have now or have ever had.

- ☐ Eye infections
- ☐ Thyroid disease
- ☐ Eczema
- ☐ Hives or rashes
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Pancreatitis
- ☐ Liver disease
- ☐ Diverticulosis
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Neuralgia or Neuritis
- ☐ Tension/ Anxiety
- ☐ Depression
- ☐ Childhood Hyperactivity
- ☐ Chicken pox
- ☐ German measles
- ☐ Scarlet Fever
- ☐ Measles
- ☐ Mumps
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Malaria
- ☐ Mononucleosis
- ☐ Venereal Disease
- ☐ Yellow Jaundice
- ☐ Tuberculosis

Current Weight: _____

Weight Loss: ___ lbs.
Weight Gain: ___ lbs.
Height: _____

MAJOR HOSPITALIZATIONS: If you have ever been hospitalized for any major medical illness or operation, write in your most recent hospitalizations below. Put an X on the following line _____ if you have had more than four such hospitalizations. (Do not include normal pregnancies).

	Year	Operation or Illness	Name of Hospital	City and State
1st Hospitalization				
2nd Hospitalization				
3rd Hospitalization				
4th Hospitalization				

MEDICINES: Mark an X in the box next to any medicines that you are now taking, or that you are sensitive or allergic to.

Taking:	***Allergic to:***	***Taking:***	***Allergic to:***
☐	☐ antibiotics	☐	☐ aspirin
☐	☐ penicillin	☐	☐ diet pills
☐	☐ sulfa	☐	☐ antacids
☐	☐ opiates/codeine	☐	☐ laxatives
☐	☐ diuretics/water pills	☐	☐ cold tablets
☐	☐ sedatives	☐	☐ _____
☐	☐ stimulants/caffeine	☐	☐ _____
☐	☐ Demerol	☐	☐ _____
☐	☐ blood pressure medicine	☐	☐ _____

Your Signature: _____ ***Date:*** _____

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Consent to use and disclose your health information

This form is an agreement between you, _____ and me/us (Linda Husser, LPC). When we use the word (you) below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at 985-662-5164 or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____

Description of personal representative's authority

Date of NPP _____ Copy given to the client/parent/personal representative.