Sherry Reeves, Psy.D.
Licensed Clinical Psychologist
870 Clark Street, Suite 1020, Oviedo, FL 32765
407-701-1135 phone 407-542-1804 fax

PATIENT INFORMATION

Today's Date _____

_____ _____
Patient Name: Last First M.I. Date of Birth

Residence/Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Email: _____

Okay to text regarding appointments ____ yes ____ no Okay to email regarding appointments ___yes ___no

Preferred contact number (*please circle one*): home / cell / work Okay to leave a message ____ yes ____ no

Marital Status (*please circle one):* Single / Married / Separated / Divorced

If Married, Spouse's Name _____

Are you employed? ____ yes ____ no _____
Employer

_____
Occupation

Please sign below giving Dr. Reeves permission to leave messages at your home via answering machine, on your cell phone via voice mail or text, and/or through email as indicated above regarding appointment dates/times and schedule changes:

X_____
(please note that no clinical information will be provided)

PARENT / RESPONSIBLE PARTY INFORMATION

_____ _____
Parent(s) or Guardian(s) Name (if patient is a minor)

_____ _____
Responsible Party Patient Relationship to Responsible Party

Home Phone # _____ Work Phone # _____

Cell Phone # _____

Preferred number for contact (*please circle one*): home / cell / work

OTHER INFORMATION

Primary Care/Referring Physician _____

Are you here due to an accident? _____ yes _____ no If yes: work _____ auto _____

Date of accident: _____ If auto accident: City, State: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

Company Name: _____

Address: _____

City: _____ State: _____ Zip Code _____

ID/Policy #: _____ Group#: _____

_____ _____

Insured's Name *(if different from patient)* Insured's Date of Birth

_____

Insured's Social Security # (if needed for insurance filing)

_____ _____

Patient Relationship to Insured Insured's Employer

Insured's Address *(if different from patient)* _____

_____

SUPPLEMENTAL INSURANCE COMPANY

Company Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

ID/Policy #: _____ Group #: _____

_____ _____

Insured's Name (if different from patient) Insured's Date of Birth

MEDICARE

ID #: _____ Effective Date: _____

Please sign below giving Dr. Reeves permission to release information (date of service, type of service, diagnosis) to your payor/insurance company *and* giving your payor/insurance company authorization to pay Dr. Reeves:

X_____

CONSENT FOR TREATMENT

I voluntarily authorize Dr. Sherry Reeves, Psy. D. to administer an evaluation and/or therapy services. I realize at the initial consultation the nature, purpose, and course of my treatment will be discussed, as well as the approximate length of treatment. I further understand that this consent can be revoked orally or in writing prior to or during the treatment period. I acknowledge that no guarantee or assurance is being made to me regarding the results that may be obtained from treatment.

OUR POLICY REGARDING CONFIDENTIALITY & INFORMED CONSENT

Confidentiality of records or information collected about you will be held in strict accordance with state laws regarding confidentiality of such records and information. Confidentiality of your records may be breached only under the following circumstances:

1. If you sign a release of information.
2. If a court orders the release of your records.
3. If you raise your mental status or competency in a legal proceeding.
4. If there is reason to believe that there is a clear and immediate probability that you will seriously harm yourself or others.
5. If there is evidence or strong suspicion of child or elder abuse.

OUR POLICY REGARDING PAYMENT FOR SERVICES

Payment is due at the time services are rendered. As a courtesy, our office will submit claims for all in-network benefits and will provide you with the necessary paperwork so that you may file for out-of-network benefits with your insurance carrier. In the event you have no benefits, or a balance is due, you will be responsible within 30 days of receipt of insurance notification or after 60 days from the date of service. Dr. Reeves reserves the right to submit unpaid balances for collection after three (3) notices are given. All balances over 60 days past due will accrue interest at 10% per year.

OUR POLICY REGARDING NO SHOW FEES & LATE CANCELLATION OF APPOINTMENTS

We request that you give at least a 24-hour notice of cancellation. We have voice mail with which you can leave your name and a full message regarding cancellation if Dr. Reeves is unavailable to answer your call. Voice mail may be activated by simply calling the office number 407-701-1135. There will be a $50 cancellation fee if notice is less than 24 hours. If you fail to call and do not show for your scheduled appointment, there will be a $75 No Show fee. You are responsible for this charge.

I have read and understand the above.

X_____ _____

Patient Signature (parent/guardian if minor) **Date**

X_____ _____

Witness Signature **Date**