# Patient Information

Name:       Date of Birth:

Preferred first name:       Is patient 18 or older? [ ]  Yes [ ]  No

Address:       City:       State: GA ZIP:

Phone:

* Confidential **voice** messages can be left at this phone number: [ ]  YES [ ]  NO
* Confidential **text** messages can be sent to this phone number: [ ]  YES [ ]  NO

Email: Confidential **email** messages can be sent to my email: [ ]  YES [ ]  NO

 If YES, use this email address:

TeleMental Health: I agree to video conferencing: [ ]  YES [ ]  NO

How did you learn about my practice: [ ]  Psychology Today web site [ ]  Insurance web site
[ ]  MikeMcNultyLPC.com web site [ ]  Other:

## Emergency Contact

Name:       Relationship to Patient:

Phone:

## Insurance Information

[ ]  I’ll be self-paying.

[ ]  I’ll be using insurance where I’m the primary insured person. Insurance Company:

[ ]  I’ll be using insurance where I’m a dependent.

 **If you check the last option**, complete the following: Insurance Company:

 Insured’s Name:       DOB:

 Address:

 (If different than patient address)

[ ]  I also have secondary insurance.

 If you check this option, complete the following: Insurance Company:

 Insured’s Name:       DOB:

 Address:

 (If different than patient address)

## Authorization

*Please read and* ***INITIAL*** *each item.*

      I authorize my insurance company to pay Michael W. McNulty, M. Div., LPC, directly for any services rendered to me by him. I authorize the release of any information required for the processing of claims or the authorization of sessions.

      I’ve read and understand the Patient/Therapist Agreement.

      I’ve read and understand the Notice of Privacy Practices.

Signature (Guardian’s signature if patient is under 18) Date