# 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

     