

## PATIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Preferred first name: \_\_\_\_\_ Is patient 18 or older?  Yes  No  
Gender (If you have insurance, this is the gender they have on record):  Male  Female  Other

Address: \_\_\_\_\_  
Street address/apt. # City, State 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) Street address/apt. # City, State ZIP

- 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) Street address/apt. # City, State ZIP

## 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