

Jim Struve, LCSW

1399 South 700 East - Suite 2
Salt Lake City, UT. 84105
801-364-5700, Ext. 1

NEW CLIENT INFORMATION

Today's Date _____

Your Name _____

Name of Guardian (if client is a minor) _____

Date of Birth _____ Soc. Sec. # _____

Current Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Your Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Occupation _____ How Long _____

Who referred you? Or, how did you learn of my service? _____

Service modality you are requesting: General Psychotherapy _____ NET _____

What is your reason for seeking therapy or consultation? _____

Have you consulted a mental health professional in the past? _____

If so, when? _____

Are you presently under a physician's care? _____ If yes, explain: _____

Do you take any medications regularly? If yes, list them: _____

Please continue on back side

In case of emergency, name of relative or friend to contact:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Name of nearest relative not living with you:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

FINANCIAL POLICY INFORMATION:

1. Full payment is expected at the time service is rendered. Any other arrangements for payment are to be discussed directly with Jim.
2. Billing receipts will be provided to you if you are filing for third party reimbursement Your bill contains all the information necessary to file claims for third party reimbursement All third party reimbursements should be made payable to you and not to Jim. If you are not filing for third party reimbursement and your check will serve as a receipt, please let Jim know so that he can minimize the usage of paper.
3. Too is not a participant with any HMO or managed-care programs. If your insurance carrier is with an HMO or managed-care company, you may still be eligible for some level of reimbursement for therapy services with Jim under the auspices of an "out of network provider" clause. Jim will be glad to discuss with you any issues concerning third party reimbursement
4. Appointment cancellations must be made at least 24 hours in advance in order to avoid being charged.

Who is responsible for payment?

Name _____ Relationship _____

Address (If different than page one) _____

City _____ State _____ Zip _____

I have read and understand the above policies:

Signature _____ Date _____