



GREAT PLAINS PSYCHOLOGICAL SERVICES CLIENT INFORMATION FORM

Appointment Date: _____

Therapist: _____

Please indicate if you plan to utilize any of the following:

- Employee Assistance Program
- Medicare
- Medicaid
- Other Insurance

Have you previously received services from our agency?

- yes
- no

Client Information: Please Print Clearly

Name: _____ Birthdate: _____ Age: _____
First MI Last

Physical Address: _____
Street Address City State Zip Code

Mailing Address: _____
 Same as Physical /Street Address City State Zip Code

Home Phone: _____ Cellular Phone: _____

School
 Employer: _____
Employer / School Name Work / School Phone

Sex: M F Social Security#: _____ Single Married Separated Divorced Widowed

Spouse / Partner or Legal Guardian (if client is a minor)

Name: _____ SS#: _____ Birthdate: _____
First MI Last

Address: _____
Street City State Zip Code

Relationship to Client: _____ Home Phone: _____ Cellular Phone: _____

Employer: _____
Employer Name Work Phone

Family Members / Others Living In Household:

| Name | Relationship to Client | Age | Birthdate | School/Employer |
|------|------------------------|-----|-----------|-----------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Medical Information

Primary Physician: _____

Current Medications: _____

Presenting Concern (Optional): _____

Referral Source:

Name of Referral Source: _____

- Attorney
- Internet Browser / Website
- Other _____
- Physician
- Employer
- Mental Health Professional
- Employee Assistance Program
- Friend / Relative
- Court

Employee Assistance Program (EAP):

Great Plains Psychological Services contracts with various companies that provide employee assistance programs to their employees and immediate family members. If your employer participates in this type of program, you are entitled to receive a limited number of services at no charge. If your employer does not currently offer this type of benefit, we encourage you to speak to your human resource representative about the possibility of implementing an EAP.

Employees of the following companies are entitled to receive EAP benefits through Great Plains. Please indicate if you are employed by any of the following:

Employee Name: _____ Relationship to Client: _____

- DakotAbilities
- Lutheran Social Services
- South Dakota Achieve
- Other EAP _____

EAP Company Name, Address & Phone # required to bill appropriately

Primary Insurance: In order to process your insurance, we must receive *complete* insurance information

Name of Insurance Company: _____

Subscriber Name: _____ Relationship to Client: _____

Insurance Address: _____
Street Address City State Zip Code

Identification #: _____ Group #: _____ Phone #: _____

Have you received pre-authorization if required? yes no not applicable

Pre-authorization will be your responsibility. Great Plains Psychological Services will provide necessary treatment information when requested by the insurance company.

Third Party Responsibility:

Please complete the following information if your account is to be billed to a third party. Please understand that we will not bill a third party unless they have provided us with written verification or a signed financial policy. Any services not reimbursed by a third party will be your responsibility.

Name of Individual and/or Agency: _____

Address: _____
Street Address City State Zip Code

Phone: _____ Has Written Authorization been provided? yes no

Assignment and Release

The undersigned hereby authorizes the release of any information relating to claims for benefits submitted on behalf of myself and/or dependent. I further expressly agree and acknowledge that my signature on this document authorizes Great Plains Psychological Services to submit claims for services rendered. I further authorize insurance companies and other third party payers to make payment directly to Great Plains Psychological Services.

Client or Legal Guardian Signature

Date