Client/Insurance Information

Noble, Alexander & Quinton Counseling Services
416 South 4th Street · Suite 1 · Danville, KY 40423
Phone (859)236-0853 · Fax (859)236-0854

Client Information

First Name ______________________________________ MI________ Last Name____

Home Address____
Street City State Zip Code

Cell Phone (   ) _____-_________ Home Phone (   ) _____-________ DOB: ____/____/____ Age: _____

SS#________ _____ _________ Gender: M___ F___ Marital Status: S M D W Race: ___________

Email Address ____Employer ____

Student: Y____ N____ School: ________________________ Grade: _______ Phone # (   ) ______-___________

Referred By: ____

Name of Emergency Contact _____________________________ Relationship _______________ Phone: (   ) _____-__________

If Applicable Name of Spouse ____

Parent/Guardian Name (if a minor) ____

Primary Insurance Policy Holder and Responsible Party Information

First Name __________________________ MI_______ Last Name_______________________ Relationship__________________

Home Address ____
Street City State Zip Code

Phone: (   ) _____-_____________ DOB: ____/____/____ SS#______ /____ /_______

Employer: ____

Primary Insurance: ________________________________ ID #:______________________________ Group#____________________

Office Billing and Commercial Insurance Procedures

- I authorize use of this form on all billing submissions, along with the release of necessary information and direct payment to my provider.
- I understand that I am responsible for the full amount of my bill for services provided.
- Deductible, co-pay, and/or co-insurance amount is your responsibility and payment is required at the time service is provided.
- There will be a $25.00 service charge on all returned checks.
- Your appointment time is reserved just for you. Kindly give a 24 hour notice if unable to keep your appointment. A $25.00 fee will be charged for all appointments missed without prior notice.

Notice of Privacy Practices/Protected Health Information (PHI)

Client Name: ____

DOB: ____________________Social Security Number: _________ _____ _________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Noble, Alexander & Quinton's Notice of Privacy Practices. If a breach of PHI occurs, client will be notified at phone numbers on file. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Noble, Alexander & Quinton's privacy officer at (859)236-0853 or by mail at 416 South 4th Street, Ste. 1, Danville, KY 40422.

____ __________________

Signature of Patient/Client Date

____ __________________

Signature of Parent, Guardian or Personal Representative * Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Crisis Plan/Telephone Consultation Agreement

I agree to pay $25.00 for each phone call (re: consultation, etc.) made after business hours. Business hours are as follows: Monday-Friday 9am - 5pm. Payment will be required prior to your next scheduled appointment.

Pamela Noble, LCSW, Gina Alexander, LCSW, and/or Ellen Quinton, LCSW do not provide emergency services. If you feel you have a crisis, utilize 911 or a local emergency room for assistance.

I agree to the above terms and conditions of billing, office procedures and crisis/telephone consultation.

____ __________________

Client Name Date

____ __________________

Witness Date

HEALTH HISTORY INFORMATION QUESTIONNAIRE

Please answer each item fully and carefully.

If you need assistance, staff will help you complete this form.

Client Name: ______________________________ Age: ____ Sex: ____Today's Date: ____/____/____

Physician's Name: ____ Phone#: __________________________

Physician's Address: ____

Date of Last Physical Exam: ____

Are you under any other Physician's care? Y_____ N_____

IF yes, Physician's Name: ______________________________________ Physician's Phone: __________________________

List all prescriptions and over-the-counter medicines you are currently taking:

Rx Name	Reason	How Often	For How Long
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________
___________________	________________	_________________	__________________

Please check any of the following problems or diseases if they apply to you or a family member:

YOU	FAMILY	YOU	FAMILY	YOU	FAMILY
[ ]	[ ] Heart Trouble	[ ]	[ ] Tuberculosis	[ ]	[ ] Asthma
[ ]	[ ] Rheumatic Fever	[ ]	[ ] Mental Disease	[ ]	[ ] Cancer
[ ]	[ ] Lung Disease	[ ]	[ ] Drug Abuse	[ ]	[ ] Epilepsy
[ ]	[ ] Alcoholism	[ ]	[ ] Hypertension	[ ]	[ ] Seizures
[ ]	[ ] Alzheimer's	[ ]	[ ] Kidney Disease	[ ]	[ ] Diabetes
[ ]	[ ] Arthritis	[ ]	[ ] Sickle Cell Anemia	[ ]	[ ] Drug Dependency (illicit)
[ ]	[ ] Thyroid Condition	[ ]	[ ] Other: ______________________________		

Have you ever been hospitalized? [ ] NO [ ] YES If yes please describe below:

Reason: ____

____

Do you have any disabilities? [ ] NO [ ] YES, If yes please describe below:

DISABILITIES: ____