

**THE PISGAH INSTITUTE FOR PSYCHOTHERAPY &  
EDUCATION, P.A.**

NAME OF DOCTOR OR CLINICIAN YOU WILL BE SEEING TODAY: \_\_\_\_\_ DATE: \_\_\_\_\_

**PATIENT INFORMATION**

NAME \_\_\_\_\_  
FIRST MIDDLE LAST PREFERRED TO BE CALLED

MAILING ADDRESS \_\_\_\_\_  
CITY STATE ZIP

RESIDENCE ADDRESS \_\_\_\_\_  
(IF DIFFERENT FROM MAILING ADDRESS)

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ S.S. # \_\_\_\_\_

MARITAL STATUS:  SINGLE  MARRIED  SEPARATED  DIVORCED  WIDOW/WIDOWER  
 DOMESTIC PARTNER

**INSURANCE INFORMATION**

PRIMARY INSURED NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
CITY STATE ZIP

HOME PHONE: \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

S.S.# \_\_\_\_\_ EMPLOYER'S NAME & ADDRESS: \_\_\_\_\_

**RESPONSIBLE PARTY FOR BILLING**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
CITY STATE ZIP

HOME # \_\_\_\_\_ WORK \_\_\_\_\_ CELL PHONE \_\_\_\_\_

**CONTACT INFORMATION**

PRIMARY CARE PHYSICIAN: NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT: NAME: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME OF ANOTHER RELATIVE OR CLOSE FRIEND NOT LIVING AT YOUR ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

**PLEASE COMPLETE ALL INFORMATION ON THE REVERSE  
SIDE**

INSTRUCTIONS: Please read the following carefully and sign in the space provided at the bottom of each section.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the Pisgah Institute to release any information necessary to process insurance claims and request payments of benefits to be made to the Pisgah Institute for services rendered to myself or my dependents. I understand that I am responsible at the time of service for paying any required co-payment and deductible.

\_\_\_\_\_  
Date \_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

SELF PAY

I have no insurance coverage. Therefore, I understand that I am responsible for payment of services rendered to myself or my dependents at the time of service.

\_\_\_\_\_  
Date \_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

INSURANCE AGREEMENT

You must call for pre-authorization if required by your insurance company, prior to your visit. If you are covered under a "MANAGED CARE" insurance company and do not call prior to your first visit for pre-authorization, you may be responsible for payment in full. Please bring your insurance card with you to your first visit. We must make a copy of it to file in your chart.

I understand that if I fail to pay amounts owed to the Pisgah Institute, the Pisgah Institute has the right to secure an outside collection agency and/or an attorney to collect the unpaid debt and to report the unpaid debt to a credit reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

I understand that I can be charged the full fee or up to the charge allowed by my insurance for any uncanceled appointment or for appointments canceled with less than 24 hour notice. I understand that these charges will not be filed with insurance. I understand these charges have to be paid in full prior to making another appointment.

\_\_\_\_\_  
Date \_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

AUTHORIZATION & CONSENT FOR TREATMENT

I hereby grant my authorization and consent to treatment and procedures deemed appropriate and certify that no guarantee or assurance has been made as to the results which may be obtained. I also give my consent for my personal health information to be shared with any other clinicians within Pisgah Institute to which I have been referred..

\_\_\_\_\_  
Date \_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

- |                     |                         |                        |                          |
|---------------------|-------------------------|------------------------|--------------------------|
| Bill Barley, Ph.D.  | Cindi Ackrill, M.D.     | Richard Johnson, Ph.D. | Danielle Mitchener, N.P. |
| Mary Berg, M.D..    | Mary Ammerman, Ph.D.    | Julie Lindsey, M. D.   | Amy Palmer, Ph.D.        |
| Stephen Buie, M. D. | Joy Breckenridge, Ph.D. | Judy McKay, M.D..      | Judy Pohl, Ph.D          |
| John Carter, M.D.   | Deborah Burns, M.A.     | Doug McKee, Psy. D.    | Pam Rogers, PNP          |
| Mary Berg, M.D.     | Steve Gold, Ph.D.       | Nancy McKeel, Ph.D.    | Terry Sloan, M.S         |
|                     | Susan Hill, EDD         | Andrea Meckley, M.A.   | Ameliann Williams, M.D.  |
|                     |                         | Scott Miller, Psy.D.   | Laura Yurko, M.A.        |