Stress Management Center

1115 Dunlap Road Anderson, SC 29621 / P.O. Box 1424 Anderson 29625
Phone 864-225-0792 Fax 864-226-3968

Patient Information

First Name _____MI_____Last Name_____
Date of Birth _____ SS#_____ Status: M/S/W/D Gender:_____
Cell Phone _____ Alternate Number _____
May we leave a detailed message at one or either number_____
StreetAddress_____City_____
State_____ Zip _____ Email Address_____

Who is financially responsible for this account? _____
Relationship to Patient and contact Phone _____
How were you referred to our office? _____

Employer/School Information of Patient

Name of Employer_____Occupation_____Yrs_____
Address_____State_____Phone_____
Name of School (If student)_____Current Grade_____

Payment & Insurance Information (If policy is not in patient's name)

Relation to Patient_____Contact phone_____
First Name _____MI__Last Name_____DOB_____
Street Address_____City_____State_____Zip_____
Employer of Insured _____Phone_____

Insurance Filing and Payment:

We are a provider for many major insurance companies. (We are not a provider for any Medicaid Program) Be sure to provide your correct and current insurance card. Patient/Parents of minors are required to pay their coinsurance or copayments on the date of service. It is the responsibility of the patient/parent to make payment for any non-covered services received, which can include but not limited to: phone consultations, records requests, letter requests and late/missed appointment fees.

I understand that payment for my portion of insurance, cash pay or other services is due on the day of service, unless other payment arrangements have been made at the office.

Signature of Patient_____Date_____

Signature Patient Representative_____Date_____

Stress Management Center
Important information

-Unpaid balances over 60 days are eligible for outside collection.
-Initial Assessment does not guarantee a follow up appointment at this practice.
-Phone consultations are $25 for each 15 Minutes.
-There will be a $25 charge for each text message sent to a Counselor.
-There will be a $30 charge for any monies returned for non-payment by any institutions.
-A fee of $50 will be charged to the account for missed appointments OR Appointments cancelled less than 24 hours before the appointment day.

This office reserves the right to dismiss any patient who is non-compliant regarding treatment or office policy/ procedures.
Our office transmits information electronically. If information is received in error by a third party, I absolve this practice of all liability.
I understand information will be given to Insurance Companies for payment of my treatment. Otherwise visits will not be filed and I will pay on a cash basis for services.
I will need to sign an authorization to release any information except to an Insurance Provider.

Signature of Patient_____Date _____

Signature of Parent or Legal Guardian
_____Date _____

EMERGENCY CONTACT_____ Phone_____

Sign and date to give permission to call if needed

_____Date_____

I give / do not give my permission to Stress Management Center to share my psychological/psychiatric diagnoses or release information/records to the following persons:

1._____Phone_____Purpose/ Relationship_____ Time Frame:_____

2._____Phone_____ Purpose/Relationship_____Time Frame:_____

I understand my medical records contain psychological/psychiatric, substance abuse or other information shared as part of my medical records for treatment. I will need to sign an authorization to release any information except to my Insurance Provider.

Signature of Patient_____Date_____
Signature Parent or Legal Guardian_____Date_____
Signature of (2nd) Parent or Legal Guardian_____Date_____

Stress Management Center
Patient Information Medical/Mental Health/Medication

Patient Name _____Birth Date_____
Primary Care Physician _____May we contact_____
Signature of Patient (to contact) _____Date_____

Personal Medical/Mental Health_____
_____
_____

Family Medical/Mental Health History _____
_____
_____

Drug Allergies_____
Food Allergies_____

Habits

Smoking____ Packs per day_____ How long _____
Coffee_____ Other Caffeine_____Type_____Amount total_____
Drugs _____ Type_____ Frequency_____
Alcohol_____Type_____Frequency_____Amount_____
Sleep Disturbance_____ Snoring_____Awakening_____Daytime Drowsiness_____

Please use the back of this as the Universal Medications Page to list all of your current medications.

I have read and understand these forms and any and all questions have been answered. I give my consent to treatment and to speak with a counselor.

Signature of Patient_____Date_____

Signature Parent or Legal Guardian_____Date_____

Signature Parent or Legal Guardian_____Date_____

Universal Medications

	Name of Medication/Supplement	Dosage	Prescriber	Condition
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				