Kent A. Tompkins, MA, LPC
Licensed Psychotherapist

2216 Scotch Pine Ct, Loveland, CO 80538 / 970.626.3333 / kent@kentart.com

Client Name ______________________ Date: ____/____/______

Address: ______________________ Phone: ______________

City/State/Zip ______________________ Birthdate: ______________

Referred by: ______________________ Social Sec. # ______________

Previous Treatment: ______________________

Major Complaint: ______________________

Martial Status: ________ Name of Spouse ______________ S.S # ______________

Names and Ages of Children: ______________________

Others in Household: ______________________

Present Medical Status: ______________ Physician: ______________

Current Medications/Dosages: ______________________

Employer: ______________ Phone: ______________

Address: ______________

Position: ______________ How Long: ______________

Name of Insured: ______________ Policy #: ______________

Insurance Company: ______________ Group #: ______________

Address: ______________

Credit Card# (optional) ______________ Exp Date: ________ Sec Code: ________

Client Email: ______________

Fee and Release Agreement: I understand that fees are due and payable at the time of service. I authorize the RELEASE OF INFORMATION required to process this and future claims with my health insurance carrier and to the referral source; and I authorize payment of benefits to the service provider. I understand that I am responsible for payment of any fees NOT reimbursed by my insurance company. I agree to pay in full for any scheduled appointment for which I FAIL TO APPEAR OR DO NOT CANCEL at least 48 hours in advance. I agree to pay for telephone contacts of a therapeutic nature. I understand of this account is 90 DAYS PAST DUE it will be turned over to a collection agency unless otherwise prearranged. Kent A. Tompkins is an individual practitioner and has NO relationship with other therapists except those disclosed in

Signed: ______________________ Date: ____/____/______

DSM V Diagnosis (office use only-if applicable

06.15.20

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