Kent A. Tompkins, MA, LPC
Licensed Psychotherapist
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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 if 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

11.23.22