Employee Assistance Patient Information (Please Print)

Patient's Name					
Address		First City/State/ Zi		MI state/ Zip:	
			Sex: M / F Date of Birth		
				Referred by:	
				If under 18, Parent:	
Employer					
Emergency Contact:		Phone:			
Address:		City/State/Zip			
Primary Insurar	nce Company:			***	
	Consent for	Treatment, Billi	ing and Notic	e of Privacy Practices:	
I, (Name of Patient/Gua	rdian/Parent)	on the behalf of	Name of Patient	, if Guardian/Parent signing)	
change/cancel. I und	derstand I will be	charged for an appo	intment not ke	prior to my scheduled apport pt or canceled at least 24 h oyee assistance program.	
	of Privacy Practic	es. I understand the	at if I have any	ty to read a copy of the Sto questions regarding the N	
By signing below I beside the item I am		ent and/or acknowl	edgement and	receipt of the four items ab	pove unless indicated
X	D 1/2 11)	Date		_	
(Signature of Patient/I	Parent/Guardian)				
X	Date		_		
(Signature of Witness)				
☐ Patient/Client Refu	ses to Acknowledge	Receipt of Privacy P	ractices:		
Signature of Staff Me	mber		Date	9	
Date of Service	CPT	Status		Other:	1
	99404				1
	99404				1
	99404				1