*Acct #*_____ *HCA Dr:*_____

HAUSER CLINIC AND ASSOCIATES
DATA INTAKE FORM

In order to assist us in providing you with quality services, and to facilitate reimbursement, please fill out this form and sign where indicated.

PATIENT INFORMATION: Referred By: _____Today's Date: ____ /____/____

Last Name: _____ First Name: _____ MI: ___

Birth Date: ____ /____/____ Current Age: ____ SSN: ____-___-_____ Sex: ____

Race: o Asian o African American o Caucasian o Hispanic o Native AM Indian o Other

Marital Status: o Single o Married o Divorced o Widowed

E-Mail Address: _____

Preferred Language: Arabic Chinese English French German Italian Japanese Korean Portuguese Russian Spanish

Patient Street Address: _____Apt#: _____

City: _____ State: _____ ZIP: _____

Phone: Home _____-_____-_____Work _____-_____-_____ Cell _____-_____-_____

Confidential Preference (contact you by): o Email o Mail o Main Phone o Phone 2 o Phone 3

Person Responsible for Payment:_____Relationship:_____

Street Address: _____Apt#: _____

City: _____ State: _____ZIP: _____

Phone: Home _____-_____-_____Work _____-_____-_____ Cell_ _____-_____-_____

Employer (or School): _____ Occupation: _____

Address_____ _____

Education Level: o GED o High School o College (associate degree) o Bachelor's Degree or Higher

Spouse's (or Parents') Name: _____ Spouse's: DOB ____ /____/____ SSN ____-___-_____

Spouse Employer: _____ Occupation: _____ City: _____ Work Phone: ___-___-____

Emergency Contact: _____ Relationship: _____ Phone: ____-____-_____

Primary Care Physician: _____ Phone: ____-____-_____

Pharmacy: _____Phone____-____-_____

Are you required by a judge, the police or a probation/parole officer to have the appointment? oYes oNo
Is the problem related to an accident or injury? oYes o No If yes, is it o automobile or o work related?
If yes, date of injury: _____
Is counseling related to a legal claim? oYes o No
If yes, Attorney:_____ Phone_____-_____-_____

I consent to treatment by a provider of the Hauser Clinic and Associates, P.A. I understand that payment is to be made at the time of the session, and that I am financially responsible for all scheduled appointment unless a minimum of 24 hours notice is given. I authorize provider of care to release my treatment records, as required, to my primary care physician and to the insurance carrier(s) for the purpose of obtaining reimbursement. I authorize payment of reasonable and customary charges to the provider of services. This release will terminate one year from my last appointment unless a written notice of extension is given.
I have reviewed over Hauser Clinic and Associates, P.A. **Notice of Privacy Practices;** I consent to acknowledgement of the Practices.

Signature of Patient/Guardian: **X**_____ Date: ____ /____/____

Signature of Witness: **X**_____ Date: ____ /____/____