Jackson
Marriage and Family
Counseling Services

1629 K Street NW, Suite 300
Washington, DC 20006
(202) 809-1174

JMFCS Patient Information & Consent Form

PATIENT INFORMATION

Date:

Patient Name: First | Middle Initial | Last

Address: | City: | State: | Zip Code:

Date of birth: / / | Age: | Sex | Marital status | Social Security #:

Phone #: | Cell #: | Work #:

Email address:

Student: ☐ Yes / ☐ No Full Time: ☐ Yes / ☐ No School/College Name:

School/College/University City: | School/College/University State:

Employer:

Employer's address:

Emergency Contact: | Relationship to patient:

Phone #: | Cell #: | Work #:

Referring provider's name: | Phone #:

RESPONSIBLE PARTY INFORMATION

Name: First | Middle initial | Last

Address: | City: | State:

ZIP Code: | Date of birth: | Age: | Sex: | Marital status:

Social Security #: | Relationship to patient:

Home phone #: | Work phone #: | Employer:

Employer's address:

Employer's City: | State: | ZIP:

INSURANCE INFORMATION

Are you covered by health insurance? ☐ If **no**, then please make payment arrangements with our business office.

Primary Insurance: _____ Policy # _____ Group #: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Social Security Number of Subscriber: _____ Copay: _____

CONSENT FOR PAYMENT

I hereby authorize payment of medical benefits billed to my insurance by Jackson Marriage and Family Counseling Services. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if Jackson Marriage and Family Counseling Services does not participate with my insurance.

No Show Fee

I agree to inform Jackson Marriage and Family Counseling Services within a minimum of 24 hours whenever I cannot keep a scheduled appointment. In the event that I feel to keep an appointment and also fail to inform Jackson Marriage and Family Counseling Services within no less than 24 hours, then I consent to pay a No Show Fee of $50.00 and I authorize Jackson Marriage and Family Counseling Services to charge my credit/debit card a one-time fee of $50.00 to cover the No Show Fee charged for my missed scheduled appointment.

Credit/Debit Card Type: ☐ VISA / ☐ MasterCard / ☐ Discover / ☐ American Express

Name as it appears on card: _____

Good Thru Date: ____ / ____ CVV: ____

Authorization to Use PHI

I hereby authorize Jackson Marriage and Family Counseling Services to use and/or disclose my personal health information (or PHI) which specifically identities me or which can reasonable be used to identify me to carry out my treatment, payment, and healthcare operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, the Jackson Marriage & Family Counseling Services practitioners can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions that Jackson Marriage and Family took before receiving my revocation.

_____

Signature of Patient or
Patient's Representative: _____ Date: _____

Printed Name of Signer (patient or representative): _____

Relationship of representative to patient: _____ (if representative is the patient, then enter "self")