REID WHITESIDE, Ph.D., P.C.

NEW PATIENT INFORMATION

PATIENT's NAME: _____ _____ _____ _____
First Middle Last Name prefer to be called by

Today's date: _____ _____ _____ Birth date: _____ _____ _____ _____
Month Day Year Month Day Year Age

Current marital status: _____ Spouse's or partner's name: _____

Service(s) requested: ___ Psychological TESTING ONLY ___ Other, not listed – Specify: _____

___ Non-clinical, e.g. COACHING, Academic ___ Psychotherapy (Individual, family, parenting, &/or couple's)

Referred by: _____ Physician's name: _____ School contact: _____

Other health care provider (psychiatrist, psychotherapist, ADHD coach, etc.): _____

PHONE - Home: ___ _____ Work: ___ _____ Cell: ___ _____ E-mail: (Use separate form)
(Place checkmark by preferred number if it is okay to call and leave a discreet message, e.g., asking you to return the phone call)

Patient's Residence Street Address: _____ City: _____ State: N.C. Zip + 4: _____

Who else may attend your sessions or take messages, if any, and their relation? _____

Do you have any disabilities under ADA now? ___ Y ___ N Are you involved in or do you anticipate ANY legal matters? __ Y ___ N

List any medications or medical conditions affecting psychological functioning: _____

Who should be contacted in a medical or psychiatric emergency? _____

COMPLETE REVERSE SIDE OF THIS PAGE IF THE PATIENT IS A **MINOR**

INSURANCE

Complete only if the PATIENT is covered by **BCBS** or the **NC State Health Plan** for mental health services and you want to apply insurance in-network toward costs. Dr. Whiteside cannot see anyone covered by **Medicare** even if BCBS is your secondary insurer.

Reid Whiteside, Ph.D., P.C. is responsible for filing claims for in-network, medically-necessary, covered charges.
Patient is responsible for co-payments, unmet deductible, authorizations, and late-cancelled or missed-appointment fees.
Patient pays out-of-pocket in full for charges for non-covered services (e.g. reports for legal or educational purposes, etc.).
BCBS and State Health restrict coverage of certain procedures and disorders, and under certain conditions.

WE MUST OBTAIN A COPY OF BOTH SIDES OF YOUR INSURANCE CARD AND A PHOTO ID AT YOUR FIRST VISIT.
*Enter all of the **policyholder's** information, even if she or he is not the patient.*

POLICYHOLDER's name: _____ **Policyholder's** birth date: _____

Policyholder's subscriber number: _____ The **policyholder** is: __ Patient __ Parent __ Spouse

Name of medical insurance company & plan: _____

Patient's policy I.D. number if different from the policyholder's: _____

1. I authorize the release of any medical or other information necessary to process this claim.
2. I authorize payment of medical benefits to Reid Whiteside, Ph.D., P.C. for services rendered.
3. I understand that claims may be filed and reimbursed by my insurer only for MEDICALLY NECESSARY SERVICES.

Signature of adult patient: _____ Date: _____
Sign on line to endorse three statements above