Kristin Areglado Hurley, LCPC, CST
Demographics & Identifying Information

CLINICIAN NAME

DEMOGRAPHICS			
Client Name			Date of Birth
Address	City	State	Zip code
Home Phone	Work Phone		Okay to call at work? Y N
Client's Sex Male _____ Female _____	Client's Marital Status: Partnered _____ Married____ Single_____ Other _____		Client's SS #
Guardian Name	Relationship to Client		Guardian Phone
Guardian Address			
Closest Relative Name, Relationship, Address & Phone			
Client's Occupation and/or Source of Income			
Client's School/Grade			
Client's Family Composition			
Client's Living Arrangements			
Client's Medications (Previous)			
Client's Medications (Current)			
Client's Allergies/Drug Interactions			
Are you currently receiving either mental health outpatient therapy or substance abuse services from another provider? Yes_____ No_____ If yes, provider name:_____			
MAINECARE/PRIMECARE			
Name	Client's MaineCare Number		
OTHER INSURANCE CARRIER			
Insurance Provider	Guarantor		
Guarantor Employer	Guarantor SS#		
Policy Number.	Group #		
Insurance Provider Address			Guarantor DOB
City	State/Zip		Telephone #
Co-pay	Referral Needed? Y N		Referral #
Primary Care Physician			**Telephone #**
BILLING POLICY / CONSENT FOR TREATMENT			

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO KRISTIN A. HURLEY, LCPC, CST FOR SERVICES NOT COVERED BY MY INSURANCE, UNLESS I AM ALSO COVERED UNDER MAINECARE. I ALSO UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR MISSED APPOINTMENTS IF I HAVE NOT NOTIFIED KRISTIN A. HURLEY, LCPC, CST 24 HOURS IN ADVANCE ($75 late cancellation fee). I HEREBY AUTHORIZE KRISTIN A. HURLEY, LCPC, CST TO FURNISH INFORMATION REGARDING MY DIAGNOSIS AND TREATMENT TO THE ABOVE INSURANCE CARRIERS AND/OR MAINECARE. I ALSO AUTHORIZE CASCO BAY CLAIMS MANAGEMENT TO OVERSEE ALL INSURANCE-RELATED MATTERS ON MS. HURLEY'S BEHALF.

I HEREBY AUTHORIZE PERMISSION FOR TREATMENT BY KRISTIN A. HURLEY, LCPC, CST.

Client/Guardian Signature: _____ **Date:** _____