Deborah G. Kabrane, LPC

555 Republic Drive, Suite 200 Plano, Texas 75074 PHONE: 972-422-9194 FAX: 972-422-9195

PATIENT REGISTRATION (Please Print)	**GUARANTOR INFORMATION**
Patient's Name	Insured's Name
SS#	SS#
Date of Birth: Age: Gender ☐ M ☐ F	Date of Birth: Age: Gender ☐ M ☐ F
☐ Employed ☐ F/T Student ☐ P/T Student	☐ Employed ☐ F/T Student ☐ P/T Student
Legal Status ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other	Legal Status ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other
Home Address	Home Address
City State TX Zip	City State TX Zip
Home Phone	Home Phone
Cellular Phone	Cellular Phone
Email	Email
If Patient is a Minor – Under age 18	**Employer**
Mother's Name	**Health Plan Name**
Phone	**Member ID #**
Father's Name	**Group #**
Phone	**Benefits Phone #**
Child Lives With	**Authorization #**

ASSIGNMENT OF INSURANCE BENEFITS / FINANCIAL RESPONSIBILITY AGREEMENT:

I hereby authorize direct payment of my insurance benefits to **Deborah G. Kabrane, LPC**, ("Provider") for services rendered to me or my dependents, I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any copayment or balance due that Provider is unable to collect from my insurance carrier for whatever reason.

NOTICE OF PRIVATE PRACTICES ACKNOWLEDGMENT / RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have reviewed the Notice of Privacy Practices for the office of Deborah G. Kabrane, LPC which explains how my personal, medical and psychological information will be used and disclosed. I understand that I am entitled to receive a copy of this document or I may print this document at http://www.myplanocounselor.com/Forms.html . I hereby authorize Provider to release any of my, or my dependent's medical or incidental non-public personal information that may be necessary for medical / mental evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, TEXT OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, text messages and e-mail. I hereby authorize Provider or her representative to mail, call, text message or email me with communications regarding my mental healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic results. I understand that I have the right to rescind this authorization at any time by notifying Provider to that effect in writing.

MISSED APPOINTMENT / LATE CANCELLATION POLICY

If you miss your appointments, you may compromise your care. A missed appointment is when you fail to show up for an appointment without a phone call or cancel without 24-hour advanced notification. I strive to be on time for your scheduled appointment and ask that you give me the courtesy of a phone call, text or email when you are unable to keep your scheduled appointment. Because I have reserved your appointment time specifically for you, missed appointments or late cancellations **without 24 hour prior notice are billed at $50.00 per missed appointment.** Missed appointments and late cancellations may not be filed with insurance and you will be responsible for the balance. By signing this statement, you are acknowledging this policy for missed appointments and late cancellations and agree to provide payment for these sessions directly or to allow Provider to charge your credit card accordingly.

TERMINATION POLICY

People terminate counseling for various reasons. Sometimes termination is premature of goals being met, while at times counseling is terminated because goals have been accomplished. I want to ensure you that it is my policy to support all termination, for whatever reason. A case will be identified as voluntarily closed after mutual discussion between Provider and client(s) or if there has been no contact with client for 60 + days.

Emergency Contact Person: ____ **Phone:** ___________________________________

Patient / Legal Guardian Signature **Printed Name** **Date**