MoryTherapy **Bill Mory, Ed.S. L.P.C., L.M.F.T.**

Marriage, Family and Individual Counseling Services | Mindfulness Training/ Emotional Brain Training

CANCELLATION WITH NO 24 HOUR NOTICE: *As a result of an increase in no-show and no-notice cancellations in 2019, we have implemented a $75.00 fee for no-show appointments, and for cancellations with less than a 24 hour notice. If a credit/debit card has been provided, the card will be used for this fee unless you indicate another form of payment. Proper notice for cancellations may be given by calling or sending a text message with your full name to 903-624-3960, or by sending an email to morytherapy@gmail.com. Thank you for your consideration.*

Thank you for choosing MoryTherapy.
We are glad you have taken this step and will work diligently with you
in the counseling process to help you achieve your goals.

If you have any questions about information from your insurance carrier or how your insurance will be applied please contact the Practice Administrator at 903.819.4449.

Below are some things you will need to do *prior to your first visit*.
Please read and DO ALL items. Thank you !

CALL YOUR INSURANCE CARRIER:

1) Ask if you have a Deductible to meet prior to using your Behavioral Health benefits.
2) Ask if you have a Coinsurance (%) or a Co-pay ($) that you will need to pay at each visit.
3) *Please be prepared to pay these amounts at your first visit.*

BRING YOUR INSURANCE CARD TO FIRST VISIT:

1) Services may be billed to you directly if you do not provide your insurance card **at your first visit**.
2) Claims cannot be submitted to your insurance carrier without a copy of **both sides** of your insurance card.

EMPLOYEE ASSISTANCE PROGRAM (EAP):

1) Ask your employer if you have an Employee Assistance Program (EAP). If so, the first few visits may be paid in full by this plan. Call the EAP BEFORE YOUR FIRST VISIT AND BRING: 1) the authorization number 2) the number of visits authorized

REMEMBER ...

- **COMPLETE ALL BOXES AND PAGES OF THIS PACKET.**
- **COMPLETE INFORMATION HELPS US TO SERVE YOU BETTER.**
- **SIGN WHERE INDICATED.**
- **KEEP THE NOTICE OF PRIVACY PRACTICES (LAST 5 PAGES)**

CLIENT ACKNOWLEDGEMENT (Required)

Signature: ________________________ **Printed Name:** ________________________ **Date:** ____________

MoryTherapy | Bill Mory, EdS, LPC, LMFT | **Today's Date**: ___________________

CLIENT INFORMATION

Last Name: | First Name: | Middle Initial

Birth Date: | Age: | Gender Identification: ☐ Male ☐ Female Other:

Physical Address: | City | State | ZIP

Social Security Number:	Cell Phone Number:	Home Phone Number:
Occupation:	Employer Name:	Employer Phone Number:

Current Primary Relationship Status:
☐ Single or Never Married ☐ Married ☐ Living with Partner, unmarried ☐ Separated ☐ Divorced ☐ Widowed

PAYMENT INFORMATION

HOW WILL YOU PAY FOR SERVICES: ☐ Self-Pay ☐ Employee Assistance Plan ☐ Health Insurance ☐ Medicaid

Person responsible for service bill: Last Name: | First Name: | Middle Initial

Birth Date: | Age: | Relationship to client:

Physical Address: | City | State | ZIP

Social Security Number:	Cell Phone Number:	Home Phone Number:
Occupation:	Employer Name:	Employer Phone Number:

INSURANCE INFORMATION: COPY OF CARD IS REQUIRED AT FIRST VISIT

Name of Primary Insurance Company: | Phone Numbers on back of Card:

Subscriber's Name:	Subscriber's Social Security Number:	Subscriber's Birth Date: Age:
Subscriber ID #:	Group #:	Employer Name:

Relationship to client:

EMPLOYEE ASSISTANCE PROGRAM (EAP) THROUGH EMPLOYER

EAP Company Name: | EAP Phone Number:

Authorization Number: | Number of Visits Approved: | Expiration Date to Use Visits:

IN CASE OF EMERGENCY

Name of Emergency Contact:	Cell Phone Number:	Work Phone Number:

Physical Address: | City | State | ZIP

Relationship to client:

CARD PAYMENT INFORMATION

Type of Card: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER ☐ OTHER: _________________________

Name on Card: | Card Number:

Expiration Date: | Code on Back (CCV): | Zip Code on Account:

Relationship to client: ☐ SELF ☐ SPOUSE/SIGNIFICANT OTHER ☐ PARENT/GUARDIAN ☐ FRIEND ☐ OTHER:

ASSIGNMENT OF BENEFITS: I authorize William (Bill) P. Mory, EdS, LPC, LMFT and representatives to release any information required to process my insurance and Employee Assistance claims. I authorize my insurance benefits to be paid directly to William (Bill) P. Mory. I understand that I am ultimately responsible for payment of all charges regardless of insurance coverage. *I understand that I will be charged $75 for any No Show or Cancellation without 24 Hour Notice for a scheduled appointment, regardless of reason, and I have provided the Card Payment Information above for the purposes of paying for and authorizing such charges.* I have read and understand the Consent for Services document as well as the HIPAA document and have been offered a copy of both. **SIGNATURE:** **DATE:**

SECONDARY INSURANCE INFORMATION: Card Is REQUIRED at first visit

Name of Primary Insurance Company:	Phone Numbers on back of Card:	
Subscriber's Name:	Subscriber's Social Security Number:	Subscriber's Birth Date: Age:
Group Number:	Employer Name:	Employer Phone Number:
Relationship to client:		

BEHAVIORAL HEALTH HISTORY AND CURRENT STATUS

What is the primary concern that brings you to counseling?

How long have you experienced this issue?

☐ Less than 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ More than 1 year

Have you ever sought treatment for or do you currently suffer from any of the following conditions?

	PAST	PRESENT	NEVER	NOT SURE	DETAILS AND COMMENTS
Schizophrenia	☐	☐	☐	☐	
Personality Disorder	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Bipolar Disorder	☐	☐	☐	☐	
Posttraumatic Stress Disorder	☐	☐	☐	☐	
Anxiety Disorder	☐	☐	☐	☐	
Obsessive Compulsive Disorder	☐	☐	☐	☐	
Phobias	☐	☐	☐	☐	
Eating Disorder	☐	☐	☐	☐	
Sleep Disorder	☐	☐	☐	☐	
Chronic Pain	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Cardiovascular/Heart Disease	☐	☐	☐	☐	
Head Injury	☐	☐	☐	☐	
Seizure Disorder	☐	☐	☐	☐	

Briefly list any previous counseling experiences you have had:

Briefly list any hospitalizations you had in the past 10 years: (Include medical, psychiatric, chemical dependency)

What changes would you like to see as a result of counseling?