Brooke Huminski LICSW
189 Governor St. Suite 202
Providence RI 02906
Tel: 401-489-6885

Demographic Information Today's Date: _____

Identification:
Full name: _____Date of Birth: _____Age:___
Phone number (s): Cell: _____
ok to leave message? ___ok to text (for scheduling purposes)? ___
Home:_____ ok to leave message? ___
Email address: _____
Street Address: _____Apt:_____
City:_____ State:_____Zip:_____

Employment:
Occupation: _____Where Employed: _____
How long at current job?_____Satisfied with job? ____Yes_____No
Highest grade level completed: _____
Specialized Training: _____

Personal:
Marital Status:_____ Children?____Yes____No; if yes, how many?____
Hobbies:_____
Religious Affiliation: _____
Emergency Contact Name: _____ Relationship to you:_____
Emergency Contact Phone: _____

Medical
Primary Care Provider: _____ PCP Phone: _____
Date of Last Visit: _____
Additional Providers Involved (Please circle): Nutritionist/RD Psychiatrist/CNS/PsychNP
Current Health or Medical
Issues:_____
_____
Current Medications and reasons: _____
_____
_____

Primary Concern:
Please describe the main difficulty that you are concerned about: _____
_____
Referred by: _____

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Payment Agreement & Cancellation Policy

Name: _____ Date: _____

SSN:_____ DOB:_____

Method of Payment: ___ Self-pay ____ Insurance

Insurance Coverage: _____

Policy # or Member ID: _____

Policy Holder info (if not client)

Name: _____ DOB:_____

Relationship:_____Phone_____

Address:_____

All patient insurance obligations (such as deductible and copayments) are due on the date of your appointment, unless other arrangements have been made ahead of time.

I hereby authorize Brooke Huminski, LICSW to release any information in the course of my treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances as mandated by State or Federal Law. **I also understand that I will be charged $75 should I not provide sufficient notice (24 hours) before cancellation of an appointment as dictated by office policy as insurance does not cover the cost of missed appointments.** In circumstances allowed by law and necessary to complete my treatment, the office will obtain prior authorization from me before releasing any medical or other billing related information. Treatment services may be billed electronically to my insurance company using the highest level of data security. I understand that I am responsible for understanding the benefits and limitations of my plan.. I have the right to view any information that this office has received regarding my medical history and billing records given reasonable advance notice. I will inform the office if I have any concerns regarding my privacy, billing records, or any other information.

_____ _____

Client Signature Date

Brooke Huminski LICSW
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Credit Card Payment Consent Form

Payee Name _____
Print Last *First* *Middle Initial*

Name on card if different _____

I authorize Brooke Huminski, LICSW to charge my card for professional services and any associated fees provided to me or to: _____, who is my _____.

(Payee initials)

_____ Any fees (as accrued) related to appointments, services, late cancellations, or missed appointments, beginning ____/____/____, and ending when treatment services are formally terminated.

_____ A payment plan related to any of the above outlined activities, beginning ____/____/____, and ending when all fees have been paid in full **or** when treatment services are formally terminated, on the following basis:

Amount $_____

Frequency: ___monthly, ___ semi-monthly, ___ weekly, ___ per visit.

_____ A one-time charge, for the amount of $_____

_____ Other: _____

Type of card: VISA ____ MASTERCARD ____ AMEX ____ DISCOVER ____

Card number: _____-_____-_____-_____

Expiration Date: _____/_____ **Security Number** (on back of card): _____

Card Billing Address Zip Code: _____

Card holder's signature:_____ **Date:** ___/___/____