GULF COAST PSYCHOLOGY

5290 SUMMERLIN COMMONS WAY, SUITE 1002
FORT MYERS, FLORIDA 33907
PHONE: 239-274-7792
FAX: 239-247-5344

Adult Patient Information Form

Patient Name:_____ **Today's Date:**_____

DOB:_____ **Age:**_____ **SSN**_____-_____-_____ **Marital Status:**_____

Home Address :(No P.O. BOX numbers please)

Address: _____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone: _____ **Cell Phone**:_____ **Email:** _____

Reason for requesting appointment: _____

_____

Approximate date or time problem began:_____ **Previous Therapy or Counseling:**_____

Are you currently taking any medications: Yes or **No** **Referred by:** _____

The person who initiates treatment is financially responsible for payment. I agree to pay for all charges not reimbursed by my insurance or not reimbursed by any other payment source, including deductibles and copayments.

Signature: _____ **Date:**_____

I was provided a copy of the Notice of Privacy Practices for review. Please sign and print your name and date below, acknowledging that you have read and understand the Privacy Practices.

Print Name: _____ **Signature:**_____ **Date:**_____

I understand that text message, email and phone call reminders are a courtesy, and it is my responsibility to remember my appointments. I also understand that I will be charged a missed appointment fee if cancellation takes place less than 24 hours before my scheduled appointment time.

Signature: _____ **Date:**_____