Heather Barcroft, M.A., LPC

Individual and Group Therapy

Client Information

Name: ____Gender: M F

Date of Birth: __________ Marital Status: S M D W School: ______________________

Employer: ______________________________ Military: ______________________

Medical Leave: Y or N Date: ____________

Referred by: ☐ Internet Search ☐ Insurance Directory ☐ Other: ______________________

☐ Professional Referral: ______________________________

Patient Home Address:____

City:____________________________________State:______Zip: __________

Home Phone #: __________________ Cell Phone #: ______________________

Email Address: ____

Parents/Guardian Name(s):____________________Spouse Name:__________________

Responsible Party name: ____________________ DOB: ______________________

Responsible Party SSN: ______________________ Relationship: ________________

Address (if different from patient):______________________________________

City: ____ State:______ Zip:________

Home Phone #: ____________________________ Cell Phone #: __________________

Work Phone #: _____________________________ Employer: ____________________

Emergency Contact Name: ______________ Phone #: ____________ Relationship:__________

I request that sensitive health information regarding my care at be handled in the following way(s):

☐ You may leave sensitive/confidential medical information on my answering machine or voice mail at the following number(s):

Daytime Phone # ______________________ Evening Phone # ______________________

☐ You may send sensitive/confidential medical information to me at the following e-mail address:

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Insurance

1 .**Primary Insurance Company**: ________________ Name of Primary Insured: ____________________

DOB of the Insured: ______________ Employer of Insured: ____________________________________

Policy #: _________________________________ Group #: ___________________________________

PCP or Pediatrician: _______________________ **Dietitian Name**: ______________________________

Address: ____________________________ Address: ______________________________

______________________________ ______________________________

Phone: ______________________________ Phone: ______________________________

Psychiatrist Name: _________________________ **Other Provider**: ____________________________

Address: ______________________________ Address: ______________________________

______________________________ ______________________________

Phone: ______________________________ Phone: ______________________________

By signing below, I (or guardian) agree to pay and be responsible for any and all billing generated by the Heather Barcroft, LPC, less any insurance payments made by in network insurance providers. I understand that payment is due upon invoice for in network insurance carriers or at the time of the service for self pay patients. Co-pays are expected at the time of service.

___________________________________ ___________________

Patient Signature Date

___________________________________ ___________________

Guardian Signature Date

12001 W Parmer Lane #200 Cedar Park, TX 78613

HeatherBarcroftLPC@gmail.com • www.HeatherBarcroftLPC.com