

Health History

Medication Currently Used:

Name	Dosage	Frequency	Prescribed by

Past Mental Health Treatment or Counseling:

Name	Dates

Authorizations and Acknowledgments

- I have received a copy of the *Welcome and Disclosure Statement* which lists my responsibilities as a client, including my privacy rights under the Health Information Health Insurance Portability and Accountability Act.
- I understand and agree that, regardless of my health insurance coverage, I am responsible for the balance of my account for any professional service rendered.
- Assignment of Insurance Benefits: I authorize the release of any information relating to all claims for benefits submitted on behalf of myself or my dependents. My signature on this document authorizes Lindsay N. Salem, Ph.D., LLC, and any professional billing service the practice may contract with, to submit claims and understand that I will be bound by this signature as though I had personally signed the particular claim. I hereby assign directly to Lindsay N. Salem, Ph.D., LLC all benefits otherwise payable to me for services rendered. I understand that any insurance benefits received by Lindsay N. Salem, Ph.D., LLC, and any professional billing service the practice may contract with, on my behalf will be credited to my account in accordance with the above agreement.
- Authorization to treat (if applicable): I authorize treatment of my minor child or ward, named as client in this document.
- I certify that this information is true and complete to the best of my knowledge. I understand that it is my responsibility to notify my therapist of any changes in the above information.

Signature

Date