**Cuda Counseling, LCSW, PLLC**

**336 E State St, Suite A Ph: (315)866-0100**

**Herkimer, NY 13350 Fax: (315)866-0101**

**143 W Dominick St**

**Rome, NY 13440**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_Today’s date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian if patient is under the age of 18: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code:\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to send text reminders for appointments: Yes or No

Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize permission to share my clinical information with my Primary Care Provider **Initial \_\_\_\_\_\_\_\_\_\_**

I authorize permission to bill my insurance and understand I am responsible for any portion of the services not covered **Initial \_\_\_\_\_\_\_\_\_\_\_**

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_

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I have been made aware of **informed consent** and **patient’s rights and responsibility/privacy policies** and I know I can obtain a copy by request or by visiting cudacounseling.org **Signature: \_\_\_\_\_\_\_\_**

**Reminder:** Due to high patient demand and the limited availability of appointments, Cuda Counseling has instituted a “No Show and Late Cancellation Fee” policy that with result in a **$60** fee if you cancel your appointment with less than 24 hours’ notice or do not show up for your appointment. Please initial your acknowledgement of this policy. **Initial \_\_\_\_\_\_\_\_\_\_\_**

Social media has become a part of many physicians’ lives and is increasingly used professionally for networking, research, and marketing. Please do not be offended when we are not able to accept “friend requests.” We need to maintain professional boundaries in order to do our job well.