Kindred

Psychological Therapy · info@kindred.bm

PATIENT INFORMATION – Please Print Clearly

Last Name:___________________________First:________________________________Middle:____________

Birth Date: __________D___________ M ___________Y Gender: Female ___ Male ___

Mailing Address: ____

____ Postal Code: _______________________

Email: ____* *Please note, we will use this email to communicate with you.*

Please circle preferred contact phone number below:

Home: __________________________Work:__________________________ Cell: _________________________

Emergency Contact Person:______________________________________ Phone: ______________________

Relationship: ___________________________________

Marital Status: Single ____________ Married ____________ Other ___________

INSURANCE INFORMATION

PLEASE CIRCLE INSURANCE COMPANY:

Insurance Co. ARGUS - BF&M – CG/Coral Isle - GEHI – HIP - FUTURE CARE – CASH – OTHER:_____________________

Policy Group Number: ________________**Certificate Number**: _________________ **Effective date**:______________

Name of Policyholder: Surname: _______________________________First Name: ___________________________
(IF NAME IS DIFFERENT FROM ABOVE)

Insured's Date of Birth: D_____ M________Y_________ **Relationship to Insured**: (Parent / Spouse)
(IF NAME IS DIFFERENT FROM ABOVE)

Employer: ______________________________________ **Occupation:**______________________________________

Referring Physician: ____

If self-referred, how did you hear about us? ____

GP Name: ____GP Phone: _____________________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize KINDRED or insurance company to release any information required to process my claim.

Patient or Responsible Party Signature: _________________________________ Date: (D/M/Y) ________________

KINDRED
info@kindred.bm
63 Victoria St., Hamilton HM 12
Tel: 232-2027

Kindred

Psychological Therapy · info@kindred.bm

CREDIT / DEBIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

CREDIT / DEBIT CARD INFORMATION		
Card Type:	☐ MasterCard	☐ Visa
Cardholder Name (as shown on card):		
Card Number:		
Expiration Date (mm/yy):		
CVC code:		

I, ________________________________, authorize Kindred to charge my credit card above for agree upon transactions. I understand that my information will be saved to file for future transactions on my account.

CLIENT SIGNATURE: ____ DATE: _____________________________

*KINDRED RESPECTS PATIENT PRIVACY. THIS FORM WILL BE ATTACHED TO YOUR CHART TO BE USED TO COLLECT PAYMENT FOR SERVICES PROVIDED.

KINDRED
info@kindred.bm
63 Victoria St., Hamilton HM 12
Tel: 232-2027

Confidentiality and Data Protection Agreement

Therapy is strictly confidential and any information revealed during therapy will not be revealed to any other person or organisation without your permission. If you threaten harm to yourself or another person, or if you threaten to destroy property, I will act in a responsible manner and inform or protect you or those at risk. If there is child abuse, physical and/or sexual, I am required to act responsibly. No action will be taken without you being informed. If you have any concerns about this, please do not hesitate to discuss this with me.

Information I hold about you is considered "sensitive" and is safeguarded to ensure that it remains confidential. Information I hold is kept to a minimum to provide effective treatment, maintain accounting, and to meet professional codes. I will not release any information about you without your expressed and informed consent.

Client notes are stored securely electronically. These records are routinely destroyed when it is clear that they will no longer be needed. You have the right to a copy of any information in your record. If you require a copy of your record please notify me in writing and I will comply within 14 days unless there are unusual circumstances.

Your signature below shows that you understand and agree with all of these statements.

____ ____________________

Signature of Client Date

____

Printed name

Consent to Treatment and Agreement to Pay for Professional Services

I acknowledge that Jessica Gordon and I have discussed psychological therapy and potential goals for treatment. I understand that developing a treatment plan with her and regularly reviewing our work toward meeting the treatment goals are in my best interest. I consent to take part and agree to play an active role in this process through regularly attending our sessions together and understand that therapy at times may be challenging before it becomes easier.

I agree to pay up front Jessica Gordon's fee per individual session for these services and to pay for services provided to me up until the time I end therapy with her. I agree that I am responsible for the charges for services provided by Jessica Gordon to me, although other persons may make payments on my account.

I am aware that I may stop my treatment with Jessica Gordon at any time. The only thing I will still be responsible for is paying for the services I have already received. If payment is not received within 2 weeks of session date Jessica Gordon has the right to end treatment.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that [if applicable] an agent of my insurance company may be given information about the type, cost, and dates of any treatments I receive. I understand that if payment for the services I receive here is not made, Jessica Gordon may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

______________________________________ ____________________

Signature of client Date

____

Printed name

I, Jessica Gordon, have discussed the issues above with the client. My observations of this person's behaviour and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

______________________________________ ____________________

Signature of psychologist Date