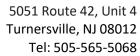




Referral / Demographics Assessment

•				
Name	DOB	SS#		
Address			Zip Code	
Home Telephone	Cell Phone N	lumber		
Which do you prefer us to call? House _	Cell			
Is it ok to leave a message? Yes No_				
Health Insurance Company				
Primary Subscriber		DOB		
Are you the Primary Subscriber? Yes	_ No			
Pharmacy Name	Pharmacy Nur	mber		
Emergency Contact				
Name	Relationship			
Telephone	Home Cell			
Any Legal or Disability Issues Pending?				
Smoker: Current Former	_ Never			
Referral Source (Who referred you to o	our services?):			
Reason for Referral (Reason you are se	eking services):			
Previous Mental Health Treatment:				
Previous Substance Abuse Treatment:				
				_



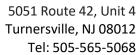


Current Medications:
Medical Issues:
Current Suicidal Ideations:
Current Homicidal Ideations:
Past Suicidal Attempts:
Current Mental Health Programs / Services:



KIC Behavioral & Counseling Services Financial Agreement

Patient Name:			
Please select one of the following financial arrangements:			
Insurance			
I hereby request that payment for services rendered to me or my child by KIC Be	ehavioral & Counseling		
Services be paid directly to KIC Behavioral & Counseling Services.	J		
Please check and complete all that apply below:			
KIC Behavioral & Counseling Services may bill my insurance for services received	l.		
Insurance ID#COPAYMENT F	COPAYMENT FEE \$		
Medicare			
I hereby authorize KIC Behavioral & Counseling services to release the Medicare authorized agent's nay information about me needed to process claims.	offices or its		
Medicare ID#INITIAL COPAYMENT \$	FOLLOW UP \$		
Flat Rate (Self Pay)			
I agree to pay the following rate each day that I engage in billable services.			
INITIAL FLAT RATE FEE \$ FOLLOW UP FLAT RATE FEE \$	_		
Patient/Responsible Party Signature			
, , , , , , , , , , , , , , , , , , , ,	Date		
Staff Signature			



__Date_____

__Date____

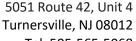


CONSENT FOR SERVICES

I have been informed of the services that I may receive from KIC E	Behavioral & Counseling Services.				
SERVICES MAY INCLUDE					
Psychiatric Evaluation	Group Therapy				
Activities of Daily Living	Family Therapy				
Medication Management	Treatment Planning				
Assessment & Evaluation	Psycho-Education Services				
Individual Therapy	Linkage to Other Services				
I consent to these services and understand that I am expected to be involved in all aspects of my care services. I will be informed and involved as new or different services are implemented.					
I understand that my decision to consent to services is volunta terminate treatment at any time. If I consider withdrawing my KIC Behavioral & Counseling Services will explain what other or decisions.	consent and/or terminating treatment, staff at				
I hereby give my informed consent to receive services from KIC Behavioral & Counseling Services.					

Patient / Responsible Party Signature_____

Staff Witness Signature_____



Tel: 505-565-5068



Dear Patients,

If you have applied for disability or are planning to, please be aware of our policies, which extends to other paperwork documents (i.e., work forms, governmental support forms, etc.):

- We cannot complete your paperwork until at least 6 visits, and this may take up to 6 months.
- We cannot send or release your documents if you have any outstanding balances.
- We charge fees for completing paperwork. The fee must be paid before paperwork is completed.
- We do expect that you will continue to attend your follow up appointment with us.

Please feel free to ask us for clarification regarding the above statements if needed.

We thank you in advance for your cooperation.

Sincerely,	
KIC Behavioral & Counseling Services	
Patient Acknowledgment / Signature	Date