Alaska Neuro/Therapy Center

Anchorage Office:
614 E. 82nd Ave, Suite 102, Anchorage Alaska 99518
Phone: 907.334.3338 Fax: 907.344. 8020
Website: ADHDance.com

Wasilla Office:
3505 E. Meridian Park Loop, Suite 220, Wasilla Alaska 99654

Date: _____

Patient Information

Patient Name: _____
Address: _____
_____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
DOB: _____
☐Male ☐Female
Email: _____
SS #: _____
Marital Status: _____
Student: ☐Full Time ☐Part Time
School: _____
Grade: _____
Patient Employer: _____
Employer Address: _____
_____
Is patient's condition due to:
☐Employment ☐Other Accident
☐Auto Accident ☐Other _____

Insurance Information

Primary Insurance: _____
Policy ID # _____
Group # _____
Policy Holder Name _____
Address (if different) _____
_____
Phone _____
SS# (of Policy holder) _____
DOB _____
☐Male ☐Female
Employer _____
Relationship to Patient
☐ Self ☐Spouse ☐Parent ☐Other

Secondary Insurance

Secondary Insurance _____
Policy ID # _____
Policy Holder Name _____
DOB _____
☐Male ☐Female
Employer's Name _____

Missed Appointment Policy

Therapy sessions are by appointment only. Because your appointment time is reserved only for you, we will charge you for appointments that are not canceled at least 24 hours in advance. Our no-show fee is $**50.00** and you will be expected to be pay this fee prior to scheduling your next visit. We do understand that circumstances beyond your control may prevent you from keeping your appointment and therefore, exceptions can be made on a case by case basis.

☐I have read, agree and understand the above missed appointment policy

Signature_____ Date_____

I grant permission for the therapist to submit information to 3rd party payers necessary to process claims. I authorize payments to be made directly to Alaska Neuro/Therapy Center, if services are not paid for at the time of the appointment. I understand that charges may be made for appointments not cancelled 24 hours in advance of scheduled appointment

Psychological and psychotherapy services are generally confidential unless the client or guardian releases the therapist to reveal information to another source. However, state law requires us to release information related to suspected child abuse and other certain situations, to appropriate authorities. I am aware of these facts and recognize that in such cases, reports to OCS, Other state agencies, and police may be made without parental or other consent.

☐I agree to the above conditions and to treatment by Alaska Neuro/Therapy Center.

Signature_____ Date_____

Names and ages of Family Members living at home

Name	Age	Name	Age
1.		4.	
2.		5.	
3.		6.	

For Parents of Children under age 18

Mother_____
Address _____
_____
Phone _____
Cell _____
Work _____

Father _____
Address _____
_____
Phone _____
Cell _____
Work _____

Visitation and Custody Arrangements

_____
_____
_____

Presenting Problems and Symptoms (Why you came to see us)

_____
_____
_____

Check all that apply:

☐Anger
☐Anxiety
☐Appetite Disturbance
☐Attention Deficit
☐Danger to Others
☐Decreased Energy
☐Depression
☐Orientation/Memory Problems
☐Paranoia
☐Poor Self Esteem
☐Sleep Disturbance
☐Suicidal Thoughts or Acts
☐Elevated Mood
☐Emotional/Physical/Sexual Trauma
☐Grief
☐Head Injury
☐Hopelessness/Helplessness
☐Hyperactivity
☐Phobia
☐Pressured Speech
☐Substance Abuse
☐Other Medical Condition
_____
☐Other, Please list:
_____
☐Impaired Judgement
☐Impulsiveness
☐Intellectual Impairment
☐Irritability
☐Marital Problem
☐Obsessions/Compulsions
☐Oppositional/Defiant
☐Panic Attacks
☐Poor Concentration
☐Sexual Problems:
Active: _____
Full Remission: _____

List any other relevant social, family, developmental or psychiatric history

_____
_____
_____
_____

How did you find us? Who were your referred by? _____