PSYCHOLOGICAL WELLNESS CENTER
THOMAS GRAF PHD

5402 HOLLY RD. STE 104, CORPUS CHRISTI, TX PH: 361-992-7780 FAX: 361-992-3355

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION:

FIRST NAME: ___________________________ AKA: _______________ LAST NAME:_________________________________

STREET: ______________________________ CITY: _______________________________ STATE: ______ ZIP: _____________

DOB: ____________________ GENDER: F/M

MOTHER:____ FATHER:____

STREET: _________________________________ STREET: _____________________________________

CITY: ___________________________________ CITY: ____

STATE: ______ ZIP: _____________ STATE: ______ ZIP: _____________

HOME #: _________________________________ HOME #: _____________________________________

CELL #: ___________________________________ CELL #: ______________________________________

EMAIL: ___________________________________ EMAIL: ______________________________________

MARITAL/CUSTODIAL STATUS OF PARENTS: SINGLE / MARRIED / DIVORCED |
IF DIVORCED PLEASE INDICATE: A. JOINT CUSTODY ____ OR
B. WHO IS CUSTODIAL PARENT PER COURT RECORDS ______________________________________

HOW MAY WE CONTACT YOU? **INITIAL ALL THAT APPLY**: EMAIL________ TEXT________ VOICE________
WHO DO WE CONTACT FOR APPOINTMENTS:____

REGARDING INSURANCE BILLING:
PLEASE READ AND SIGN:

I understand that Thomas Graf, PhD and Psychological Wellness Center does not have my insurance information and will not bill my Insurance for services provided to me. As a courtesy you will be given an invoice for each day of service that you can submit to your insurance. They may reimburse you, if services are covered. We will not be able to contact your insurance for any verification of benefits as that would trigger HIPPA regulations.

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

SIGNED: ______________________________________ DATE: ____

WITNESS: ______________________________________ DATE: ____

PSYCHOLOGICAL WELLNESS CENTER
THOMAS GRAF, PHD

5402 HOLLY RD STE. 104, CORPUS CHRISTI, TX 78411 PH: (361) 992-7780 FAX: (361) 992-3355

Authorization to Release/Obtain Protected Healthcare Information

This form, when completed and signed by you, authorizes our office to release/obtain confidential health care information from your clinical records to/from the person(s) you designate.

I, ____

(Patient's Name or minor child's name)

authorize **Thomas Graf, PhD** and/or the administrative staff to:

INITIAL and COMPLETE:

A) _____ Release information to:

____

____

B) _____Obtain information from:

____

____

C) Information released:____Treatment Notes_____Psychological Evaluation____Progress Updates_____Entire Record

_____(_____________________________).

You have the right to revoke this authorization in writing at any time by sending notification of such to our office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization. To

BEGIN OF PERMISSION: ____________________________ **END OF PERMISSION:** _ ______________________________.

SIGNATURE OF PATIENT/PARENT OF MINOR ___________________________________ **DATE** _____________________

SIGNATURE OF WITNESS____ **DATE** _________________________

THOMAS GRAF, PhD

PSYCHOLOGICAL WELLNESS CENTER

5402 HOLLY RD STE. 104, CORPUS CHRISTI, TX 78411 PH: (361) 992-7780 FAX: (361) 992-3355

NO SHOW / NO 24 HOUR ADVANCED CANCELLATION POLICY

Your Doctor or Counselor will set aside 1 hour of devoted time for your needs.

Therefore if you are unable to make your appointment, a **24 hour** advanced notice will be required to avoid a No Show Fee of **$85.00**.

Confirmation of each appointment the day before is a requirement.

Cancelling on the day of your appointment **WILL** incur a No Show Fee.

I accept the above policy.

SIGNATURE: ____ **DATE:** ________________________

Thank you,

Dr. Thomas Graf