Amanda Reedy, LCSW
500 Bannock Street
Boise, ID 83702
Telephone: (719) 210-5479

Patient Name (legal name):____

Patient Name (preferred name):

Gender Identity:__

Pronouns: _

Date of Birth:_____/_____/_____ Age:_

Address:
_____

City:_____State: _____ Zip:_____

Cell Phone: _____ Home Phone:_____

Permission to leave message at the above phone number(s): Y / N

Email:_____

Permission to email receipts and/or appointment reminders: Y / N

Preferred Correspondence: Phone / Text (SMS) / Email

Employer / School :_____

Marital Status: Single / Married / Divorced / Widowed /Partnered

EmergencyContact/Relationship:_____Phone:_____

Parent / Guardian Name (for minors:) _____

Members of Household: _____

Current Medications, Supplements & Vitamins (Dosage, Duration): _

Current Payment Plan:

Blue Cross / Blue Shield / Other Insurance / Self Pay

Policy Number:_____Group Number:_____

All fees are expected at the time of service. Please make sure you contact your insurance BEFORE the appointment so that you know what your co-pay/deductible is for services. You are also in charge of making sure I am listed as a provider within your insurance plan. We will file with your insurance for you but if there is a problem with billing (such as I am not in network with your specific plan), you are responsible to pay any amounts your insurance does not pay.
If you are unable to make it to your appointment, please call in advance whenever able as a courtesy for my time. If you miss more than 1 appointment without calling in advance you may lose your time slot and can be charged for missing appointments.

Please **initial** each of the following:

_____I authorize release of information to ALL of my insurance companies.

_____I authorize payment directly to my therapist from the insurance company.

_____I understand that I am responsible for my bill.

Date: /_____/_____Signature: ___

Referred by_