Dedham Consultation Center, LLC

339 Washington Street, Suite 203
Dedham, MA 02026

New Patient Information:

Name____ Date of Birth ______________

Address____

City/Town____State___________________

Zip Code_____________________ Home phone ( )__________________________

Work Phone ( ) ________________ Cell Phone ( ) _________________________

Email: ____

(I understand information sent via text or email may not be confidential.) **Initial here:________**

Emergency Contact Person ____

Emergency Contact Person Phone Number ( ) _____________________________

Insurance Plan: ____

Subscriber name: ____

Number____

<u>Please read and sign below:</u> (Parent/Guardian signatures needed if patient under 18)
By providing this insurance information I am authorizing Dedham Consultation Center, LLC. or their agents, to use my protected health information for the processing of Insurance Claims, Coordination of Care, and the Continuation of Treatment as indicated.

Signature_______________________________________ Date____________________

I authorize the direct payment of the insurance claims or the assignment of benefits to Dedham Consultation Center, LLC

Signature_______________________________________ Date____________________

I consent to treatment (medication prescribed and/or therapy) provided by Dedham Consultation Center, LLC.

Signature____Date__________________

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Coordination of Care Authorization:

I authorize Dedham Consultation Center, LLC to have Verbal/Written contact with the following persons: (information discussed will be pertinent to the coordination of care and treatment, used for billing purposes, and other purposes as specified by law.)

Primary Care Physician ____

Address____

State _________ Zip Code______________Phone _________________________

I Authorize _____ Do not Authorize_____ contact with Primary Care Physician

Signature ____ Date_______________
(If under 18 please have parent or guardian sign)

Therapist ____

Therapist Address____

Therapist Phone Number____

I authorize______ Do not Authorize______ contact with my referring therapist

Signature ____ Date_______________
(If under 18 please have parent or guardian sign)

Family Member, Close Friend or Additional Member of Care Team (ie. Nutritionist, Previous Provider) involved in my support network:

Name_____________________________________ Phone ( ) __________________

I authorize _______ Do not Authorize______ contact with Family members or Identified Support Network

Signature____ Date______________
(If under 18 please have parent or guardian sign)