New Approaches Consent to Treat

Services Interested in: ☐Mental Health ☐Substance Misuse

Name (First, MI, Last): _____ Social Security # _____

Gender: ☐ Male ☐ Female ☐ Other: _____

Date of Birth: _____/_____/_____ **Marital Status:** ☐ Single ☐Married

Address: _____

City, State, Zip: _____

Phone (H): _____(C)_____(W)_____

Email:_____ Primary Care Provider: _____ Referring Provider: _____

*We may wish to communicate upcoming appointment information, test results and/or other information regarding your medical care. What is the best phone number for contact where we may also leave messages?

☐ Home ☐ Cell ☐ Work

Emergency Contact: _____

Relationship: _____ Phone: _____

Can the above listed contact (with photo identification) pick up prescriptions if you are unavailable? ☐Yes ☐No

If you would like to give us permission to discuss personal information in your medical record with someone other than yourself, please fill out the Permission to Discuss Form.

Race	Preferred Language	Ethnicity
☐ **White**	☐ **English**	☐ **Non-Hispanic or Latino**
☐ **Black or African American**	☐ **Other: _____**	☐ **Hispanic or Latino**
☐ **Asian**		☐ **Other: _____**
☐ **American Indian or Alaska Native**		
☐ **Native Hawaiian or other Pacific Islander**		
☐ **Other: _____**		

Primary Insurance:	*Secondary Insurance:*
Insurer ID#:	**Insurer ID#:**
Group #:	**Group #:**
Claims Address:	**Claims Address:**
Subscriber:	**Subscriber:**
Subscriber's Date of Birth:	**Subscriber's Date of Birth:**
Relationship to Patient: **☐ Self ☐ Spouse ☐ Other**	**Relationship to Patient:** **☐ Self ☐ Spouse ☐ Other**

The above information is thorough and accurate to the best of my knowledge. Any changes to the above information will be communicated with the office.

I consent to evaluation and treatment by any provider at New Approaches. I hereby authorize release of medical information that is necessary for my further treatment.

_____ _____

Patient Signature (or Guardian) Date