Richard L. Benson, Ph.D., P.A.
Licensed Psychologist
5750 West 95th Street, Suite 320
Overland Park, KS 66207
Phone 913/596-8808 Fax 913/242-7358
www.bensonpsyc.com

ADULT NEW PATIENT FORM

Patient Name: ______________________ **Date of Birth:** ____________
Age: ______ **Gender:** Female Male
Address: ____
Cell: ____________ **Work:** ____________ **Email:** ____________
Employer: ____________ **Position?** ____________ **How long?** ____________
Spouse/significant other's Name ______________________________
Address: ____
Cell: ____________ **Work:** ____________ **Email:** ____________

Primary Care Physician's Name: ______________________________
Address: ____
Phone: ____________ **FAX:** ____________

Medical Issues:
Currently being treated for: ______________________________
In past treated for: ______________________________

Medications:
Name: ____________ **Dosage/Frequency** ____________ **By** ____________
Name: ____________ **Dosage/Frequency** ____________ **By** ____________
Name: ____________ **Dosage/Frequency** ____________ **By** ____________

Purpose for seeing Dr.Benson: ______________________________

Referred By: ______________________________

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Signature/Acceptance Page

Please initial and date all applicable statements below:	**Initial**	**Date**
I agree that all charges incurred by me or my dependent(s) are my responsibility to pay (unless some other written authorization has been obtained).	______	_____
I understand that 24 hours notice (1 business day: Friday if appointment is on a Monday, or the business day prior to a holiday if appointment is the day following a holiday) must be given if an appointment must be cancelled to avoid being charged the full fee for the appointment.	_____	_____
I assign payment of insurance benefits to this office. I understand that I am completely responsible for any penalties, denials, or disputes of non-payment for services by my insurance company.	_____	_____
I authorize the release of any medical or other information necessary in order to process my insurance claims.	_____	_____

I have reviewed all the information on the New Patient Form and, to the best of my knowledge, it is correct and complete. I acknowledge that I have been given access to Dr. Benson's Psychotherapist-Patient Services Agreement and the HIPAA Notice Form (on his website at www.bensonpsyc.com) and agree to abide by their terms.

____
Printed Name of Patient (Parent if Patient is a Minor)

____ _____________
Signature of Patient (Parent if Patient is a Minor) Date