Effective Change, LLC;
Matthew Brittain, MA, LCSW, DCSW, DABFSW
224 Kamehameha Ave. #207 Hilo HI 96720 (808) 934-7566

NAME ______________________ BIRTH DATE ____________ GENDER______ AGE________

PHYSICAL ADDRESS: ____________________ CITY______________ STATE HI ZIP__________

MAILING ADDRESS: ____________________ CITY ______________ STATE HI ZIP __________
(If different from residence)

EMAIL ADDRESS: ____

TELEPHONE (home)______________ (Cell phone) ______________ (Other) ____________

HEALTH INSURANCE PLAN:____________________ INSURANCE NUMBER:______________

Second responsible person to call in case of emergency, including their phone number: ______________

PHYSICIAN'S NAME ____

A $7.50 to $30 Copayment will be charged. Amount varies depending on the type of medical coverage. QUEST plans have no copayment. Please let me know if you have financial difficulty and need special arrangements.

CONFIDENTIALITY: All information between therapist and client is held strictly confidential except when 1) the client authorizes release of information with a signature; or 2) the therapist is ordered by a court to release information or if there is litigation by the client against the therapist; or 3) the client presents a physical danger to self or others; or 4) child/elder abuse, exploitation or neglect is suspected. In these latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken. Diagnosis and other information release minimally required for billing/documentation purposes is a standard procedure and is authorized by my signature below for release to insurance companies or other payers as appropriate. I authorize the insurance company/other payer to pay for services rendered. In addition, by signing below I authorize any emergency personnel to provide treatment to my child or legal ward if the need arises.

Cancellation Policy: You are responsible for keeping your appointments. Commercial Insurance, Private Pay and selected other pay plans will be charged the usual copayment amount for sessions cancelled within 24 hours of scheduled time (late cancellations) and for no-shows. Aloha Care, HMSA QUEST, Medicaid/Medicare will be charged $5 for any late cancellations or no-shows. Three missed appointments or late cancellations in any 6-month period will result in referral to other providers. If you need reminding of your appointments please indicate such so that reminder calls can be made to you.

Do we have permission to call or leave a message on voice mail or text or email ? **Yes [ ] No [ ]**

SIGNATURE ____ DATE______________