Welcome to the office of
Victor E. Loos, Ph.D.

Please review/fill out the pages below, as follows:

- ❑ Notice of Privacy Policy (tri-fold brochure)
  Yours to review/keep.

- ❑ Client Information (pgs 1&2)
  Fill out as much as you can.

- ❑ Insurance Information (pg 3)
  Fill out the top part and sign the bottom
  (If you've already given us your insurance information you can skip to the bottom and sign.)

- ❑ Office Policies (pg 4)
  Please sign and date.

- ❑ Acknowledgement of Receipt
  Please sign and date.

CLIENT INFORMATION

Patient Name:_____

Date of Birth:_____ Social Security #:_____

StreetAddress:_____

City:_____ State:_____ _Zip Code:_____

Telephone numbers: Home:_____ Cell:_____

Work: _____ May I contact you at work? _____

E-mail:_____ May I communicate with you via e-mail?_____

Preferred form of communication: Home ph_____ ___work ph_____ Cell_____ E-mail_____

If patient is 18 yrs. Old or younger

Mother's Name: _____

Street Address: _____

City: _____ State:_____ Zip Code:_____

Telephone numbers: Home:_____ Cell:_____

Work: _____ May I contact you at work?_____

e-mail:_____ May I contact you via e-mail?_____

Preferred form of communication: Home ph_____ __work ph_____ Cell_____ E-mail_____

Father's Name: _____

Street Address: _____

City: _____ State:_____ Zip Code:_____

Telephone numbers: Home:_____ ___Cell:_____

Work: _____ May I contact you at work?_____

e-mail:_____ May I contact you via e-mail?_____

Preferred form of communication: Home ph_____ work ph_____ Cell_____ E-mail_____

HOUSEHOLD FAMILY MEMBERS

Name	Relationship	Birth date	Age

Whom may we thank for referring you? _____

Please briefly describe your reason for seeking consultation: _____

_____

Personal Health

Are you currently on medication? ( ) Yes ( ) No

Do you presently have any physical health problems? ( ) Yes ( ) No

Have you seen a mental health professional before? - if so, please provide any brief comments you think might be

Helpful. _____

_____

_____

For office use only
Date:_____ DX._____ Therapist:_____ CYS:_____

INSURANCE INFORMATION

If you believe insurance and/or Crime Victim's Assistance may cover a portion of your visits here, please complete the following information:

Name of Patient: _____

Name of Insured:_____ D.O.B._____SS#_____

Address: _____

City:_____ State_____ Zip Code_____

Phone numbers: Home_____ Work_____

Relationship to Patient: _____

Employer's Name: _____

Phone: _____

*Insurance Company*_____

Phone _____

*Group#*_____ *Policy#*_____ *ID#*_____

AUTHORIZATION TO ASSIGN BENEFITS AND TO RELEASE INFORMATION

I hereby authorize Victor E. Loos, PhD. To bill my insurance company and authorize payment of psychological and supplemental benefits to the above: and to release information to the insurance company with respect to claims with Dr. Victor E. Loos.

I agree to accept full responsibility for all charges incurred by me and agree to pay for all charges not covered by insurance.

_____ _____

Signature of Patient / Parent / Guardian ***Date***

_____ _____

Witness *Date*

CENTER FOR FAMILY CONSULTATION

Victor E Loos, PhD., Director

2524 Nottingham Houston, TX 77005-1412

Phone (713) 526-4751 Fax (713) 5264342

Office Policies

PLEASE NOTE:

1. Please cancel appointments 24 hours in advance to avoid payment, except in case of emergency.
2. I will help you with insurance forms, but the responsibility for payment lies with the client, who may be reimbursed by the insurance company.
3. Payment is requested at the time of each visit.
4. Confidentiality to you is assured within the constraints of the law.
5. Phone messages will simply state "office of Victor Loos" with no reference to doctor's office or psychology sessions.
6. E-mail messages will be brief and seldom contain information about clinical material.

For white listing e-mails to avoid spam filters may come from vloos@cffc-online.com or office@cffc-online.com

_____ _____

Client's signature Date

CENTER FOR FAMILY CONSULTATION

Victor E Loos, PhD., Director

2524 Nottingham Houston, TX 77005-1412

Phone (713) 526-4751 Fax (713) 5264342

ACKNOWLEDGEMENT OF RECEIPT

HIPAA "Notice of Privacy Policy"

This is to verify that I have been given a copy of the *Notice of Privacy Policy* for the office of *Victor Loos, PhD.* I understand that, after reviewing it, I may ask for any clarification I might need. OK.

_____ _____

Patient/Guardian Signature Date