[ ] There have been no changes in the insurance information from last year (CURRENT PATIENTS ONLY).

Patient Information

Kathleen M. Vogler, Ph.D., H.S.P.P.
KMV Psychological Services PC

First Name: _____ Middle: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security # _____ Birth Date _____ Age _____

Contact Information	May we leave a message	Preferred Courtesy Call Method
Home Phone: ( ) _____	Yes / No	_____
Work Phone: ( ) _____	Yes / No	_____
Cell Phone: ( ) _____	Yes / No	_____
E-mail: _____		_____

Marital Status:
Single ____ Married _____ (spouse's name _____) Divorced____ Separated ____ Widowed ____

Education or Highest Grade Completed: _____ Occupation: _____

Military Experience: Current Service Member _____ Veteran ____ Family Member _____ (Parent, Spouse, Child)

Employer: _____ Employer Address _____

Emergency Contact Name: _____ Phone: ( ) _____ Relationship

Primary Insurance Co. _____ Secondary Insurance _____

Insurance ID # :_____ Insurance ID # : _____

Policy / Group # : _____ Policy / Group # : _____

Phone : ( ) _____ Phone : ( ) _____

I, the undersigned, agree and consent to participate in the mental health services offered and provided by **Kathleen M. Vogler, Ph.D.,** a psychologist, as defined in Indiana law. I understand that I an consenting and agreeing only to those mental health services that the above named practitioner is qualified to provide within the scope of the provider's license.

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered.

I understand and agree that (regardless of insurance status) I am ultimately responsible for the balance on my account for the professional services rendered. I also understand that if collection proceedings are necessary, I will pay all fees associated with collecting this bill.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/ Legal Guardian if Patient is a Minor Date

438 S Emerson Avenue, Suite 153
Greenwood, Indiana 46143
317-886-7804
Fax 317-884-6130

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Patient Information – Page 2

Primary Insured Person or Guarantor

☐ **Same as page 1**

First Name: _____ Middle: _____ Last: _____

Relationship to Patient _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone : ( ) _____ Work Phone: ( ) _____ Cell ( ) _____

Social Security # _____ Birth Date _____ Age _____

Marital Status: Single _____ Married _____ Divorced_____ Separated _____ Widowed _____

Employer: _____ Employer Address: _____

Spouse's Name: _____ Spouse's Occupation: _____
Spouse's Employer: _____ Spouse's Work Phone: _____

Who guided you to our office?
_____ Physician Referral Physician Name: _____
_____ Insurance / EAP Referral
_____ Friend / Relative _____ School _____ Website _____ Other: _____

Describe what brings you to our office: _____
_____
Have you received previous counseling -- if so, when, for what, and with whom? _____
_____

Family Physician: _____ Physician Phone: _____
Medical Conditions (please list):_____
Allergies: _____

CURRENT MEDICATION

Medication	Dose	Prescriber	When Prescribed

Please list **any previous medications** taken to treat anxiety, depression or other mental health issue _____
_____

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