



Rebecca K. Olander, PMHNP-BC, LLC
 Amanda K. Schnee, PhD, LLC
 Carrie Semke, PhD, LLC
 Casey Voichoskie, LIMHP, RPT, PC
 Shayla Hinrichsen, PMHNP-BC, LLC
 Eryn McMaster, PhD, LLC
 Alex Reznicek, LMHP, LLC

5539 S. 27th Street, Suite 101, Lincoln, NE 68512
 Phone: 402-261-6212 Fax: 402-817-4949

Patient Name (Last) _____ (First) _____ (Middle) _____
 Address: _____ Home Phone#: () _____ - _____ Cell#: () _____ - _____
 City: _____ State: _____ ZIP: _____
 Date of Birth: ____/____/____ Soc. Sec# _____ - _____ - _____ Male: Female:
 Race: _____ Ethnicity: Hispanic or Latino Not Hispanic or Latino Preferred Language: _____
 Single: Married: Separated: Divorced: Widowed: Email: _____

Parent/Spouse's Name: _____ Soc Sec# _____ - _____ - _____
 Date of Birth: ____/____/____ Email: _____

Purpose of Visit: _____
 Referred By: _____ (Doctor name, Friend, Yellow Pages, etc.)
 Primary Care Physician: _____ Phone: () _____ - _____
 Emergency Contact: _____ Phone: () _____ - _____

Do You Have Medical Insurance? Yes No (If Yes Please Answer **ALL** Questions Below)
 Primary Insurance Company _____
 Policy # _____ Group# _____
 Does your insurance require authorization prior to the first session? Yes No If yes have you contacted the company? Yes No
 Policy Holder's Name & Relationship _____
 Policy Holder's Soc Sec# _____ - _____ - _____ Policy Holder's Date of Birth ____/____/____
 Policy Holder's Employer's Name _____ Employer's Phone #: () _____ - _____
 Employer's Address _____

Secondary Insurance Company _____
 Policy # _____ Group # _____
 Policy Holder's Name & Relationship _____
 Policy Holder's Soc Sec # _____ - _____ - _____ Policy Holder's Date of Birth ____/____/____
 Policy Holder Employers Name: _____ Employer's Phone () _____ - _____
 Employer's Address _____

Responsible Party or Guarantor (if other than patient): _____
 Address: _____ Phone: () _____ - _____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my provider to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Encompass Care, LLC that is otherwise payable to me for his/her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to individual providers will be credited to my account in accordance with the above assignment.

 (Print Name of Patient) (Authorized Signature of Patient/Parent/Guardian) (Date)
 Note: If the patient is under the age of 19, their parent or guardian must sign all legal documents provided. Revised 8/2020