NEWPORT PSYCHOLOGY GROUP

KERRY K DELK Ph.D., Inc.
2900 Bristol St., Bldg. H, Suite 103, Costa Mesa, CA. 92626

PERSONAL INFORMATION

PATIENT NAME:_____ DOB:_____ Age:_____ Gender: M / F

CELL PHONE (___)_____HOME PHONE:(___)_____ WORK PHONE:(___)_____

HOME ADDRESS:_____ CITY:_____ ZIP:_____

EMPLOYER:_____ POSITION:_____

ADDRESS:_____ CITY:_____ ZIP:_____

YEARS OF SCHOOL:_____ MARITAL STATUS:_____ SOCIAL SECURITY #:_____

SPOUSE'S NAME:_____ AGE:_____ OCCUPATION:_____

SPOUSE'S EMPLOYER:_____ WORK PHONE:(___)_____ Ext.___

IN CASE OF EMERGENCY, CONTACT:_____ PHONE:(___)_____

IF THE PATIENT MINOR, PLEASE PROVIDE NAMES AND ADRESSES OF ALL LEGAL CUSTODIAL PARENTS BELOW.
MOTHER:_____ ADDRESS:_____ PHONE:(___)_____

FATHER:_____ ADDRESS:_____ PHONE:(___)_____

RELEASE OF INFORMATION TO MY PHYSICIAN

_____I hereby authorize the exchange of verbal and written information between NEWPORT PSYCHOLOGY GROUP, Kerry K Delk Ph.D., Inc. and his staff) and my Primary Care Physician (Physicians Name:)_____.
This may include psychological and substance abuse assessment, diagnostic, treatment plan and discharge information from my record and is to be used exclusively for the coordination and continuity of care between my therapist and physician.
_____ I do not wish to authorize a release of information to my physician. _____ I do not have a Primary Care Physician.

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE and INTERNAL AUDIT

PRIMARY INSURANCE:_____ POLICY #:_____ Group #:_____

POLICYHOLDER:_____ DOB: _____ SOCIAL SECURITY #:_____

SECONDARY INSURANCE:_____ POLICY #:_____ Group #:_____

POLICYHOLDER:_____ DOB: _____ SOCIAL SECURITY #:_____

The undersigned authorizes Newport Psychology Group, Kerry Delk Ph.D. Inc and the treating therapist _____ to release, and to obtain information from the insurance carriers for the following purposes: **(Initial all information to be released)**.
*_____Clinical management and coordination of Patient's mental health under the Patient's health benefit plan.
*_____To allow payment by Patient's third party payor and for administration, quality assurance, and utilization review purposes.
_____ Other (Describe): _____

The medical records and information concerning the Patient hereby authorized to be released. **(Initial all information to be released)**

*_____ Attendance	_____ Psychosocial History and Diagnosis	_____ Progress notes
*_____ Psychological Assessments	_____ Substance Dependency Assessment	_____ Treatment plan
_____ Consultation Reports	_____ Discharge reports and Summaries	*_____ Copayment History

_____ Records created by other providers, the patient's physicians, or the patient that are contained in the NPG record.

*_____ I authorize Newport Psychology Group and Kerry Delk Ph.D. to conduct internal audit and review of my treatment documents.
This Consent shall expire in **(Initial One)**: ___ 60 days after termination of treatment; ___ Other (Describe): _____, unless otherwise provided by state law.

_____ _____ _____
Signature of Patient or Legal Guardian **Relationship to Patient** **Date**

_____ _____
Signature of Witness/Clinician **Date**