

**MINDFULNESS-BASED STRESS REDUCTION CLINIC**

**PATIENT DATA**

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Thank you for filling out these forms. We realize the personal nature of these questions.  
Please be assured that the completed forms are kept in strict confidence.

Patients Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street

City State Zip Code

Phone # (home) \_\_\_\_\_  
(work) \_\_\_\_\_

E-mail address \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_

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**Health Insurance Information**

**Services for the MBSR Clinic can be billed under mental health benefits and most often require preauthorization by the subscriber. We will assist you in every way to obtain coverage but can not guarantee that coverage will be provided for you. It will be your responsibility to insure that all necessary steps are taken to obtain coverage. Please call the number listed with your insurance carrier to receive all necessary information and to obtain preauthorization (if required) to access your benefits. It will be necessary to provide them with the following information:**

Services will be provided by Steve Flowers, MFT

The CPT (service) codes for our program are:

- 8 units of 90853 (group therapy)
- 2 units of 90801 optional (diagnostic interview)

**It will also be necessary to provide your insurance company with a diagnosis. If you are not currently in medical treatment and do not have a physician or counselor that can provide a diagnosis, this can be provided to you after an intake interview to participate in this program.**

Primary Insurance Carrier \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

**\*Please enclose copy of current insurance card for our records**

**MINDFULNESS-BASED STRESS REDUCTION PROGRAM  
PARTICIPATION AGREEMENT**

To attend the program we ask that you make a commitment to us and to **yourself**:

1. To not miss more than one session of the eight week series. If there is an emergency that prevents you from attending, please call the instructor within a few days of the missed session.
2. To practice the meditation, relaxation and/or mindful body movement for forty-five minutes, six days a week for eight weeks.
3. Attend the **7** hour retreat to the best of your ability.

Participants who keep these commitments tend to gain the most benefit out of the program. Remember to assess whether this is a good time in your life right now to be able to embark on a significant lifestyle change.

If you agree to make these commitments, please sign:

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

We will provide you with encouragement, support and guidance to help you complete the program and accomplish your goals.

\*This form is only necessary to fill out if you have been referred by a physician

Mindfulness-Based  
Stress Reduction Clinic

**CONSENT FOR RELEASE OF INFORMATION**

I authorize the release of medical information concerning my treatment in the Stress Reduction Clinic to my Referring Physician (the physician we receive the referral from) and to myself.

Consent to release medical records **to your Referring Physician** (please check one):

**YES:** \_\_\_\_\_

**NO:** \_\_\_\_\_

**\*\*Please note that if we Do Not receive a referral from your physician, there will be no medical record sent out.**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Patient's Name (PLEASE PRINT)**

\_\_\_\_\_

**Patient signature**

\_\_\_\_\_

**Parent or legal guardian's signature**

**MINDFULNESS-BASED  
STRESS REDUCTION CLINIC**

**INFORMED FINANCIAL AGREEMENT**

I understand that I am responsible for the full cost of this program and will pay any balance for my participation in this program (unless special financial arrangements apply).

Furthermore, I acknowledge I will be responsible for the entire cost of the program after I have completed the first class of the program series and whether or not I am able to attend all classes in the program series (again, unless previous arrangements have been made).

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**Please Print Name**\_\_\_\_\_

**Date**\_\_\_\_\_

\_\_\_\_\_  
**Patients Signature**

\_\_\_\_\_  
**Parent or Legal Guardian**  
*(if patient is a minor)*

**MINDFULNESS-BASED STRESS REDUCTION CLINIC**  
**PARTICIPANT AGREEMENT**

Welcome to Stress Reduction & Mindfulness Meditation. Before entering the program, it is important that you understand what we are asking of you in terms of your level of participation and commitment.

This program is designed to help you learn mind and body awareness techniques to cope with physical or psychological symptoms from stress, chronic pain and illness and/or stress-related illnesses.

You will begin to experience the benefits of participation in Stress Reduction Mindfulness Meditation in a short period of time. However, the program requires commitment on your part. In order to experience the benefits of the program, you must make a strong commitment to attend each of the sessions and practice the meditation, relaxation and gentle movement exercises regularly during the eight weeks.

We understand that entering the program involves a significant lifestyle change and time commitment to attend the sessions and to meditate and do the exercises for thirty-five minutes daily. However, it is likely that you will find these activities pleasurable and empowering. Long after you have completed the program, you will be able to use the techniques and skills you've learned to enhance your health and improve the quality of your life.

**On** a scale from ,to 10 how certain do **you feel that you** can commit to. approximately **35** minutes of practice a day, **5-6** days a week while you are in the program? Please circle a number.

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Definitely Not	Very Certain
1   2   3   4   5   6   7   8   9   10	