INTAKE FORM Clinician's Name: Amanda Bradshaw, MA, CAGS, LMHC

Date______________

PERSONAL INFORMATION:

Patient Name ____Date of Birth________________________

Address____

City/State/Zip____

Phone Home (____)_________________Cell (_____)__________________Office (_____)________________

Email Address: ____

Who referred you to our office? ____

RESPONSIBLE PARTY: (fill in if under 18 or if someone other than patient is responsible for payment)

Name ____

Address____

City/State/Zip____

Home Phone (_____)________________________Business Phone (_____)_____________________________

INSURANCE INFORMATION:

Primary Insurance Company____

Provider Phone (located on back of card) (   )____

Subscriber Name (if other than patient) ____

Date of birth:____

Insurance ID#____

FINANCIAL POLICY

Appointments cancelled with less than 24-hour notice will be charged **$75.00**.
I am responsible for the entire balance of services performed regardless of whether there is insurance coverage.
Secondary insurance will be billed as a courtesy.
I understand and agree to the above stated financial policy.

Signed ____Date_______________________________

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR INSURANCE

I authorize the use or disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Signed ____Date_______________________________

I authorize payment of medical benefits to my provider for services performed.

Signed ____Date_______________________________