

INTAKE FORM

Clinician's Name: Allison Mattison, Psy.D. Date _____

PERSONAL INFORMATION:

Patient Name _____ Date of Birth _____

Address _____

City/State/Zip _____

Phone Home (_____) _____ Cell (_____) _____ Office (_____) _____

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 _____