INTAKE FORM Clinician's Name: **Cecilia M. Duarte Ph.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 _____ **Date of birth** _____

Address_____

City/State/Zip_____

Home Phone (_____)_____Business Phone (_____)_____

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_____