INTAKE FORM Clinician's Name: Faith LaMunyon, LICSW 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_____