

**INTAKE FORM**

Clinician's Name: Paula Cofoni, LICSW, LCDP 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 \_\_\_\_\_