NEW CLIENT INTAKE FORM

Therapist: **DEBORAH L. GALINDO, Psy.D.** Account #_____

PATIENT INFORMATION:

Patient Name: (Last, First, MI) _____

Patient Address: (Street/PO Box) _____

(City, State & Zip) _____

Patient Telephone No: Home _____ Work _____ Cell _____

Patient's Employer/Student: _____ Soc. Sec. No. _____

Patient's Physician: _____ Patient Date of Birth _____

Relationship to Insured: _____ Sex: M F Marital Status: S M D W

RESPONSIBLE PARTY INFORMATION: (The person who signs this agreement will be the responsible party. For a minor, you must be the parent, adoptive parent, or legal guardian.)

Resp. Party Name: (Last, First, MI) _____ DOB: _____

Resp. Party Address: (Street/PO Box) _____

(City, State & Zip) _____

Resp. Party Phone: Home _____ Work _____ Cell _____

Resp. Party Employer: _____

SSN: _____ Sex: M F Relationship to patient: _____ Marital Status: S M D W

PRIMARY INSURANCE SUBSCRIBER INFORMATION:

Name: (Last, First, MI) _____ DOB: _____

Address: (Street/POBox) _____ Sex: M F

(City, State & Zip) _____ Marital Status: S M D W

Phone: Home _____ Work _____ Cell _____

Employer: _____ Relationship to patient: _____

Name of Insurance: _____ Ins. 800 phone no. _____

Member ID No: _____ Group No: _____ Date Effective: _____

SECONDARY INSURANCE SUBSCRIBER INFORMATION:

Name: (Last, First, MI) _____ DOB: _____

Address: (Street/PO Box) _____ Sex: M F

City, State & Zip) _____ Marital Status: S M D W

Phone: Home _____ Work _____ Cell _____

Employer: _____ Relationship to patient: _____

Name of Insurance: _____ Ins. 800 phone no. _____

Member ID No: _____ Group No: _____ Date Effective: _____

PROVIDER/CLIENT SERVICE AGREEMENT

(Initial to the left of each section to indicate your agreement)

_____(Initial) I have reviewed my provider's Informed Consent material and the Provider Policy on Insurance and Billing Practices and understand the provisions contained in it.

_____(Initial) I authorize the following people access to the information I specify below. [Please put the name(s) of those who have access to the information areas identified below. By doing so, you are indicating that you authorize the release of your scheduling or account information to them, as needed. Be sure to include your spouse <u>if</u> you wish that person to make appointments and/or have access to billing information.]

Scheduling Information	**Billing Inquiries**
1.	1.
2.	2.

_____(Initial) I authorize my provider to use and disclose the necessary health and clinical information for me or _____for the purposes of payment and health care operations. I authorize payment of medical benefits to my mental health provider for services rendered.

If you would like to provide your email address we will email you one week in advance of your appointment to confirm.

Preferred email address: _____

You will also receive a text or call to confirm your appointment two days in advance. If you would like to opt out of these reminders please inform staff at the time of your appointment.

_____(Initial) I understand my provider holds the right to charge me for the full amount of the session if I do not cancel 24 hours in advance.

_____(Initial) I understand it is my responsibility to provide current, correct insurance information now and to inform this office within 30 days of any insurance coverage change. I do understand that my provider bills my insurance company as a courtesy to me and that any denied claim becomes my responsibility. Finally, I understand that my provider reserves the right to charge me for administration costs to rebill claims if I have not provided current, correct insurance information.

_____(Initial) If applicable, as parent or legal guardian of _____, I have read the Contract for Therapy with Minor form. I consent to evaluation and treatment of my minor child and agree to be responsible for any costs incurred.

I understand the above and agree to the provisions for those sections I have initialed above.

Please Print Name _____

Signature _____ Date _____

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