

# NEW CLIENT INTAKE FORM

Therapist: **MICHAEL TREMKO, PMHNP-BC** Account # \_\_\_\_\_

Check Location preference: Salem \_\_\_\_\_ Oregon City \_\_\_\_\_ (both) \_\_\_\_\_

## **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/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: \_\_\_\_\_

## **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)**

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

\_\_\_\_\_ I authorize the following people access to the information I specify below. [Please put the  
 (Initial) 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 if you wish that person to make appointments, be able to talk to your provider and/or have access to billing information.]

	Clinical	Scheduling	Financial
1.		1.	1.
2.		2.	2.

\_\_\_\_\_ I authorize my provider to use and disclose the necessary health and clinical information for  
 (Initial) 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.

**Contact arrangements** (optional):

Preferred phone contact number: \_\_\_\_\_

Preferred email address (if applicable): \_\_\_\_\_

Skype (optional): user name \_\_\_\_\_ phone \_\_\_\_\_

\_\_\_\_\_ I am requesting a telephone call / email (circle preferred option) notification as a reminder for my  
 (Initial) scheduled appointments. I understand that the email or telephone call is a courtesy that in no way relieves me of the responsibility of keeping my scheduled appointment. I understand my provider will charge me for the full amount of the session plus \$100 if I do not cancel 24 hours in advance. This fee will not be reimbursed by insurance.

\_\_\_\_\_ I am willing to have the office contact me via my email address regarding billing questions.  
 (Initial)

\_\_\_\_\_ I understand it is my responsibility to provide current, correct insurance information now and to  
 (Initial) 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.

\_\_\_\_\_ If applicable, as parent or legal guardian of \_\_\_\_\_, I have read the  
 (Initial) 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 \_\_\_\_\_