



Today's date: _____

NEW PATIENT INTAKE FORM

If the patient is a minor, we ask the parent to include the section indicated.

NAME OF PATIENT: _____ AGE: _____
Last First MI

D.O.B: ____/____/____ SEX: M F SS#: ____/____/____
MM DD YY

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ E-MAIL: _____

WORK PHONE: (____) _____ EXT. _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SPOUSE'S NAME: _____ AGE: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE: (____) _____

EMERGENCY CONTACT: _____ PHONE: (____) _____

REFERRED BY: _____

If client is a minor, please complete the following section:

MOTHER'S NAME: _____ PHONE: (____) _____

ADDRESS (if different from above): _____

FATHER'S NAME: _____ PHONE: (____) _____

ADDRESS (if different from above): _____

Biological Parents: _____ Married _____ Divorced Year of Divorce _____

Custody Agreement (pertaining to doctor's decision making and financial responsibility for child).

Financially responsible party:

NAME OF PATIENT/PARENT/GUARDIAN: _____

SIGNATURE OF PATIENT/PARENT/GUARDIAN: _____

SS#: ____/____/____ D.O.B.: ____/____/____ DRIVER'S LICENSE (State & No.) _____

AUTHORIZATION FOR RELEASE OF INFORMATION FOR INSURANCE

I hereby authorize the release of information from my record to my insurance company's or employer's insurance/claims department, related to the assessment, diagnosis, treatment, and prognosis of the mental condition for which I am receiving care. I hereby authorize payment of medical benefits directly to The Center for Learning and Behavioral Solutions, Inc., for services provided. I agree that a photocopy of this authorization shall be as valid as the original document.

Insured: _____ Relation to Patient: _____ Insured DOB: _____

INFORMED CONSENT

The following information is intended to help answer some questions you may have about our services, fees, and office policies. Please read and sign this form to indicate that you understand and accept these conditions. If you have any questions, please do not hesitate to ask.

The Center for Learning and Behavioral Solutions is a multi-specialty group of independent practitioners, providing a variety of psychological and behavioral services. Specifically, we provide individual, relationship and group psychotherapy, educational and psychological testing. If the patient's needs are not within our field of expertise, we will assist you in finding an appropriate referral.

APPOINTMENTS/CANCELLATION/NO-SHOWS: Please refer to our Appointment and Cancellation Policy for details. Generally, all treatments are conducted within the confines of the office. Where phone consultations are necessary, you will be billed if the duration of the phone call exceeds 10 minutes. You are not billed for routine scheduling or information calls. Insurance carriers do not customarily cover phone consultations; be sure to consult your carrier for details.

INFORMED CONSENT: We keep a record of our patient's information. This record contains the dates of contact with our patient, the patient's health and development history, notes on the patient progress, and other documents relevant to the patient's treatment. This record is confidential and may be released only with written consent by the patient/parent/guardian. Insurance carriers require a limited release to authorize treatment. To release information to a third party, the Center for Learning must receive from the patient/parent/guardian, a completed and signed "Release of Information to Third Party" form.

PAYMENTS/INSURANCE: Our policy is to **collect payment at the time of service**. The Center for Learning & Behavioral Solutions, Inc. is "an out-of-network" provider. If the patient is covered under a private insurance, the "deductible" must be met before the insurance will begin to pay towards the patient's services. The insurance deductible is the financial responsibility of the patient/financially responsible party, and will be billed up front. If the patient/guardian requests or requires services that are not covered under the patient's insurance, these charges will be billed directly to the patient/financially responsible party.

We strongly recommend you consult with your insurance company to determine your mental health coverage.

Please be advised that account balances over 30 days will be charged interest of 1.5% per month and may be sent to the collection agency thereafter. A fee for collection of normal payment of services may also be added where necessary.

MESSAGES: The office manager and staff are generally available Monday through Friday 9:00 a.m. to 4:00 p.m. During this given time period, you may call to schedule appointments, ask any questions, and leave messages. If you call and no one is available to direct your call—or you call after normal business hours—you may leave a message on the Center's voice-mail service. Please include your name, the time, a brief message and a daytime phone number where you can be reached. **If you have a life-threatening emergency, please call 911 immediately.**

Patient/Parent/Guardian Signature

Print Name

Date