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: _____

SCHOOL: _____ GRADE: _____ REFERRED BY: _____

EMERGENCY CONTACT: _____ PHONE: (_____) _____

If patient is an ADULT, please complete the following section:

EMPLOYER: _____ OCCUPATION: _____

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

WORK PHONE: (_____)_____ CELL PHONE: (_____)_____

SPOUSE'S NAME: _____ AGE: _____

SPOUSE'S EMPLOYER: _____WORK PHONE: (_____)_____

If patient is a MINOR, please complete the following section:

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

CELL PHONE: (_____) _____ E-MAIL: _____

ADDRESS: _____ CITY: _____STATE:_____ ZIP: _____

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

CELL PHONE: (_____) _____ E-MAIL: _____

ADDRESS: _____ CITY: _____STATE:_____ ZIP: _____

Custodial Arrangements (pertaining to doctor's decision making and financial responsibility for child):

Financially responsible party:

NAME:_____ Relation to Patient: _____

SIGNATURE:_____

MAILING ADDRESS: _____ CITY: _____STATE:_____ ZIP: _____

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: _____

Center for Learning & Behavioral Solutions, Inc.
16220 Scientific Way, Irvine, CA 92618
Phone: 949-654-2424 Fax: 949-654-2428 www.C4L.net

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, Inc. 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; therefore, patients are responsible for their entire bill. If applicable, the Center for Learning will provide a Superbill (an itemized bill which breaks down all of the sessions attended) to our patients with Out-of-Network coverage upon request, after their bills have been paid; however, it is up to the patient/financially responsible party to follow up with the insurance company.

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.

BILLING/FINANCIAL RESPONSIBILITY: Center for Learning & Behavioral Solutions, Inc. provides one bill for services rendered, which is mailed directly to the authorized financially responsible party.

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, call 911 immediately.**

The Center for Learning utilizes electronic communication in order to keep our clients informed. If you would like to opt out of receiving electronic updates regarding services, promotions, newsletters, etc. please initial here_____

_____ Relation to Patient: _____
Patient/Guardian Signature

_____ Date:_____
Print Name

_____ Relation to Patient: _____
Guardian Signature

_____ Date:_____
Print Name

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