Insurance Intake Form

Patient Name_____ Date of Birth_____/_____/_____
Age_____ Male/Female

Street Address_____SS#_____

City_____ State_____ Zip_____

Marital Status: Single Married Separated Divorced Widowed

Phone:
Home_____Work_____Cell_____

Referred by: _____

Responsible Party (if different from above)
Address_____
Phone_____
Emergency Contact_____ Phone_____
Relationship_____

Primary Insurance Company_____
Policy Holder _____DOB: _____

Social Security #_____

Policy Number_____

Group Number_____

Relation to Patient_____
Employer Name_____
Employer City/State: _____

Copay/Coinsurance_____Deductible_____
Deductible met? YES NO

Is patient covered by another insurance policy? NO YES - If yes, please enter name of second company below: Secondary Insurance
Company_____
(Please note that we do not file secondary insurance claims, but can give you a receipt for you to file.)

Primary Care Physician: _____
Phone_____

Expectations from Therapy: Client's Responsibilities

People utilize therapy to help change what are often significant aspects of themselves (attitudes, behaviors, emotions, etc), their relationships (marriage or significant other relationships such as with parents, friends, children, other relatives, etc.) or other circumstances in life (employment, living environment, etc.) in order to reduce or alleviate problems and to lead a more fulfilling life. As a client, you will be expected to take an active role. As a professional, I can assist in effecting change, but cannot guarantee a specific outcome. You will determine the direction and be ultimately responsible for growth. If at any time you are dissatisfied with your therapy, please let me know in order that we can work together toward a solution.

SERVICE AGREEMENT

1. Appointments must be canceled at least 24 hours prior to the appointment or the client will be billed for that session.
2. Out-of-office consultations---hospital visits, court appearances, or other types of consultations (which require the therapist to leave the office to provide counsel or consultation) can be provided to the client at a fee of $250 per session hour.
3. On services covered by insurance, you, as the client are responsible for payment.
4. Consultation with referral sources on the client's behalf will be billed at the existing rate for the portion of the time utilized to provide the consultation.
5. Therapy sessions consist of a 50-minute "hour". If session last longer than 50 minutes, they will be billed on a pro-rated basis.
6. Fees for individual therapy per 50-minute session is $90.00. The Fee for marital/couple therapy is $130/session.
7. Payment is due when services are received. Make checks payable to Lena Pearlman, LCSW.
8. If for any reason payment for services is not received within thirty (30) days after the services were rendered, there will be a $25 per month carrying charge.
9. There will be a $25 charge on all returned checks.

I understand the above policies and agree to these provisions.
Signed_____

Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices