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Valley Stream, NY 11580
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First Date of Treatment _____
DSM Code# _____
Returning Patient _____

INTAKE FORM- Please bring completed form on your first visit.

A. Personal Information

Patient Name _____ Date of Birth _____
Address _____ M F
City/State/Zip _____ Marital Status _____
Home Phone () _____ Work #() _____ Cell# () _____
Social Security # _____ Email Address _____
Primary Care Physician _____ Phone # () _____
Address/City/State/Zip _____

B. Responsible Party (Fill in if under 18 or someone other than patient is responsible for payment)

Name _____
Address _____
City/State/Zip _____
Home Phone () _____ Work #() _____
Relationship to Patient _____

C. Insurance Information

Primary Insurance Company _____
Address _____
City/State/Zip _____ Phone # _____
Insurance ID# _____ Group # _____
Name of Insured (if different from patient) _____

D. Insurance Coverage Information (if known)

Annual Deductable _____
Insurance coverage per session 100% 80% 50% other _____
How much coverage per Calander Year? \$ _____ or number of sessions per year _____
Co-Payment per session \$ _____ Other _____

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E. Authorization Information

Authorization # _____ Number of Sessions Authorized _____

Date Authorization Starts _____ Date Authorization Ends _____

For Authorization Call () _____ ext _____ Fax # () _____

F. Self-Pay/No Insurance

I agree to pay \$ _____ per session at the time of service.

Signed _____ Date _____

G. Billing Information

Send Claims to Primary/Secondary Insurance _____

Send Claims to insurance but collect from Patient _____ Responsible Party _____

Send Bills for co-payments/deductible to Patient _____ Responsible Party _____

Send HCFA form to Patient _____ Responsible Party _____

Special Instructions _____

H. Financial Policy

Appointments cancelled with less than 24 hour notice will be charged at the full session fee.

I am responsible for the entire balance of services performed regardless of whether there is insurance coverage.

Secondary Insurance is billed as a courtesy,

I understand and agree to the above financial policy.

Signed _____ Date _____

I. Authorization for release of Information & Assignment of Benefits of Insurance

I authorize the use or disclosure of my personal health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that the organization is authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Signed _____ Date _____

I authorize payment of medical benefits to my provider for services performed.

Signed _____ Date _____

If there are any changes in your circumstances please notify this office immediately.