

# Patient Intake Form

Note: in the case of divorced parents, the parent signing this form is considered ultimately responsible for all fees.

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## Patient Information

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_ M F

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parent's names (if minor) \_\_\_\_\_

Home phone: \_\_\_\_\_ Phone # for urgent matters: \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

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## Insurance Information

Primary person covered under insurance \_\_\_\_\_ Date of birth \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different): \_\_\_\_\_ City, state \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Ins. ID No. \_\_\_\_\_

Ins. Co. phone \_\_\_\_\_ Employer/ Occupation \_\_\_\_\_

Business address \_\_\_\_\_ Business phone \_\_\_\_\_

\*We bill only to primary insurance carrier. We will be happy to furnish receipts and explanation of benefits to help you submit to secondary carrier.

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I, the undersigned, certify that I (or my dependent) have insurance coverage as listed above and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I have read, I understand, and I agree to the Patient Financial Agreement and Notice of Privacy Practices. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize Danielle Putrow, PsyNP to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

I give Danielle Putrow, PsyNP permission to treat myself/ my dependent.

Printed name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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**CHANGES/ UPDATES TO ABOVE (including date and patient initials):**