CLIENT INTAKE FORM

Date:_____ Provider:_____

Child's Name: _____ DOB:_____

Parent/Legal Guardian:_____

Address: _____

City: _____ State: _____ Zip: _____

Home:_____ Cell:_____Work:_____

Email Address: _____

Do you authorize our practice to call you at the above numbers and leave a message regarding the appointments? Yes or No (Please specify exceptions: _____)

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School: _____ Grade: _____

Child's Pediatrician: _____

Medications:_____

Previous Medical Diagnosis:_____

Previous Developmental Diagnosis:_____

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I authorize payment of Insurance benefits to Chelsea Place Psychological Services. I authorize the release of any medical or other information necessary to process claims. I acknowledge that I understand the Notice of Privacy Practices (HIPAA) and that any questions I have had about it have been answered.

I also understand that I will be responsible for any payments (copay, deductible, etc) and services that are not covered by insurance. You will receive an invoice for any outstanding balance, including services not covered by your insurance.

_____ _____

Signature to be kept on file Date

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Insurance Company:_____

Insureds Name:_____

ID#:_____ Group #:_____