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STUDENT & CHILD INTAKE

Today's date: _____ Referred by: _____

Child's Name: _____ Birthdate: _____ Age: _____

School: _____ Grade: _____

Ethnicity: _____ Pronouns:_____ Gender Identity: _____

Parent 1 Name: _____ Is this person the child's legal guardian? Yes No

Parent 1 Address: _____ City/State: _____ Zip: _____

Parent 1 Home Phone: _____ Cell Phone: _____ Fax: _____

Parent 1 Employer: _____ Work Phone: _____ Can you be called at work? Yes No

Parent 2 Name: _____ Is this person the child's legal guardian? Yes No

Parent 2 Address: _____ City/State: _____ Zip: _____

Parent 2 Home Phone: _____ Cell Phone: _____ Fax: _____

Parent 2 Employer: _____ Work Phone: _____ Can you be called at work? Yes No

Please list names of all persons who have legal authority to consent to psychological evaluation/treatment and/or release of records for this child:

_____ _____ _____

Child's Primary Care Physician: _____ Physician Phone: _____

Name of Emergency Contact: _____ Contact's Phone: _____

<u>Please list below the name and address of the person who is the responsible billing party:</u>

Name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Signature: _____

Insurance Carrier: _____ Insurance Phone: _____

Insurance Co. Address: _____ City/State: _____ Zip: _____

Subscriber ID Number: _____ Group #: _____

Name of Subscriber: _____ Subscriber's Birthdate: _____

necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, we will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Client Signature (Parent/Guardian if Minor) Date

_____

Printed Name

_____ _____

Co-Signature (if required) Date

_____

Printed Name of Co-Signer

Please sign and return with your Intake form. You should have received a complete copy of this form, If not, or if you have any questions, please contact Dr. Provenzano.