Boise Psychological Services Intake Form

Please choose: Michael Eisenbeiss Victoria Thompson Laura Root Diane Hakes Jane Krumm

Referred by ________________________________

PATIENT

Last Name __________________________ **First Name** ___________________________ **Middle Initial** _______ M F

Date of Birth ______________________ Home # ________________ Work # ________________ Cell # _________________

Home Address ____ City ___________________ State________ Zip __________

Employer/School __________________________________ Spouse/Parent______________________________________

RESPONSIBLE PARTY: Self (If Self, skip to next section)

Last Name __________________________ **First Name** ___________________________ **Middle Initial** _______ M F

Relationship to Patient: Spouse Mother Father Other_____________________

Date of Birth ______________________ Home # ________________ Work # ________________ Cell # _________________

Home Address ____ City ___________________ State________ Zip __________

INSURANCE SUBSCRIBER: Self (If Self, skip to next section)

Last Name __________________________________ **First Name** _____________________________ **Middle Initial** _______

Relationship to Patient: : Spouse Mother Father Other________ **Employer**_________________________

Date of Birth ______________________ Home # ________________ Work # ________________ Cell # _________________

Home Address ____ City ___________________ State________ Zip __________

INSURANCE INFORMATION: (Fill in OR Attach copy of insurance card)

Company____ Phone and Area Code________________________________

Address____ City ___________________ State________ Zip __________

Policy or ID #____ Group #____

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, & FINANCIAL POLICIES

- I authorize the release of my medical or other information necessary to process my insurance claim.
- I request that payment of medical benefits be made directly to practitioner named above.
- I understand that **all co-pays & deductibles are due at the time of service**.
- As the responsible party, **I am accountable for all charges of professional services rendered** on behalf of identified patient, including charges not reimbursed by insurance, unless special arrangements have been agreed upon in writing. I further acknowledge my responsibility to pay all charges if my account is turned over to a collection agency.
- I understand that **I may be billed for missed appointments & for late cancellations (less than 24hrs notice**). Repeated no shows or late cancellations may result in being dropped from the provider's practice.
- My signature below indicates that I have read & understand the financial policies. As Patient/Guarantor, I acknowledge that should this account be assigned to a collection agency due to non-payment, I will be liable for any collection fee(s) charged by the agency plus any other collection costs incurred, such as reasonable attorney fees and court costs.

RELEASE OF CONFIDENTIAL INFORMATION: Please ask receptionist for additional form to request your medical records to/from other medical providers.

PATIENT SIGNATURE (If 15 years old and older)______________________________________ Date ___________________

PARENT/GUARDIAN (For Minors) ____ Date ___________________