PATIENT INTAKE FORM

Which provider are you seeing? ___________________

PLEASE FILL IN COMPLETELY: **Is this an EAP or Workman's CompCase?________**

Is this a legal case? ____________

Patient Name_____________________________________ Date of Birth _______________________

Address________________________________ City_________________St________Zipcode___________

Home Phone (_____)_______________Work Ph (____)_______________Cell/Pager(____)_____________

Emergency Contact__________________________Relationship___________Phone__________________

I give permission for the following person(s) to have access to ( )appointment info; ( ) medical info:

Name(s): _____________________________________ Phone(s)____________________________

Patient SS#____________________Occupation____________________Highest level education__________

Ethnicity (circle one) Caucasian African American Asian Hispanic/Latino American Indian Other

Personal/Family Physician__________________________ How did you hear about us?_________________

Are you currently being treated by another mental/behavioral health professional? Yes No

Name of other provider(s) and reason for treatment:____

INSURANCE INFORMATION (COMPLETE IN ENTIRETY)

Insurance Company Name____

Insurance Phone_____________________________ Authorization #'s for visit________________________

Policyholder's Name________________________ SS#___ ____________________Birthdate_____________

Policyholder's Address (if different from above)____

Policyholder's Employer____

Membership ID#___________________________________Group #_________________________________

Policyholder's Relationship to Patient (circle one): SELF SPOUSE PARENT OTHER:________________

PLEASE READ CAREFULLY BEFORE YOU SIGN THIS DOCUMENT: I understand that I am responsible for my entire fee. I authorize Psych Associates of Maryland, L.L.C. to bill my insurance company directly and receive compensations for services rendered. Since some insurance companies require precertification, I will call my insurance company to inform them of my choice to utilize services from Psych Associates of Maryland, L.L.C. **Payment is expected at the time of service. In the event that my account becomes delinquent and is forwarded to an attorney for collection, I am responsible for the attorney fees and all court costs. Additionally, I will be responsible for full payment of the missed appointment fee when 24 hours' notice is NOT given for cancellation.** I also authorized Psych Associates of Maryland, L.L.C. to send treatment plans to my insurance company in order to obtain future authorizations. I understand that Psych Associates of Maryland, L.L.C. is an independent practitioners' group. I give my full consent to the Physicians, Psychologists, Social Workers and Psychotherapists within the group to exchange information to facilitate treatment. I understand that I can revoke this consent at any time with a written notice.

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Signature of the patient or individual responsible for payment Date