**Intake Form**

***\*\* Please Print \*\****

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_ Age \_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Partner’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By \_\_\_\_\_\_\_\_\_\_\_

Family Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance and Billing Information**

Name of Insured/Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_ / \_\_\_ / \_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Read and Initial for Billing Insurance and Use of Your Information**

\_\_\_\_ I authorize use and release of this information to my insurance company for billing purposes.

\_\_\_\_ I authorize direct payment of services to my service provider Dr. Jim LeFan.

\_\_\_\_ I understand checks returned incur a fee of $25; if sent to collections a fee of 20% of the total remaining balance will be added to the unpaid balance.

\_\_\_\_ I understand my deductible, co-pay(s), co-insurance amounts, and/or any other balance not paid by insurance is my responsibility and due on the time and day that services are provided.

\_\_\_\_ **To cancel a session I understand I must call 512-328-9632, at least 24 hours before my start time. If less than 24 hours I will be billed $125.00. Two missed sessions without proper notice will remove you from the schedule and require calling to restart therapy and set a new date and time.**

Name of Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_