**Jim LeFan, Ph.D.** 512-328-9632 phone/fax
3939 Bee Caves Road, Suite A-5, Austin, Texas 78746 jimlpsych@icloud.com

# 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 consecutive sessions without proper notice will remove you from the schedule and require calling to restart therapy and set a new date and time.

Signature of Patient/Responsible Party ________________________________ DOB ___ / ___ / ___