INTAKE FORM

Cost of Therapy:
15-minute Initial Phone Consultation – Free
45-minute Full Consultation – $160
60-minute hypnotherapy Session – $200

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PATIENT INFORMATION

Last Name		*First Name*	*Middle Name*	*Today's Date:* / /		
Is this your legal name?	☒ YES ☐ NO	If not, what is your legal name?	(Former name)	Birth Date	Age	Sex

Street Address	*Apartment/Unit #*	*Social Security Number*	*Home Phone No.*
P.O. Box *City* *State* *ZIP Code*			*Cell Phone No.*
Occupation	*Employer*		*Work Phone No.*
Email Address			

PRIMARY CONTACT INFORMATION

Name	*Relationship to patient*
Phone No.	*Address (If different)*
Email Address	

INSURANCE INFORMATION

Policy Holder's name	*Birth Date*	*Address (if different)*	*Home Phone No.*
Email Address	*Member ID No.*	*Group No.*	*Cell Phone No.*
Occupation	*Employer*	*Employer Address*	*Work Phone No.*
PRIMARY INSURANCE PROVIDER	☐Blue Cross/Blue Shield ☐Cigna ☐Aetna ☐Beacon ☐Other: _____		
Will you be using EAP's (Aetna or Cigna only)?	☐YES ☐NO	If YES, what company is the EAP through? _____	*EAP Authorization No.* / *No. of sessions authorized*

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	*Relationship to Client*
Home Phone No.	*Work Phone No.*

HOW DID YOU HEAR ABOUT US

☐Internet Search ☐Friend ☐Facebook ☐Advertisement Another Dr.'s Office /Dr.'s Name: _____ ☐Other: _____

INTAKE FORM CONTINUED …

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PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I agree to further honor contractual agreements made with Calm and Clear Mind Center (Service Agreement and Office Policies) document and those with my managed health care companies, which stipulate specific reimbursement restrictions.

X_____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment for myself or my child by the specified provider. Although the chances for obtaining my (his/her) goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment for my child or myself at any time. I understand that I am responsible, however, for any balance for services rendered.

X_____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary Protected Health Information (PHI) for treatment and insurance reimbursement purposes.

X_____

CLIENT/GUARDIAN SIGNATURE DATE

GENERAL CONSENT

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You may leave the following information blank if you do not require or wish for any of your family members/ persons to be informed about your treatment plans, medical conditions, and or diagnosis.

Should you wish to change, add, or omit this information at any time, please contact our office.

Print names of any family members / persons that you wish to grant permission to be informed about your treatment plans, medical conditions, and or diagnosis. *(Please note: If no names are provided, our center will not disclose any information to individuals inquiring about your information. Per HIPAA regulations we may disclose information when absolutely necessary for your protection and wellbeing).*

*Name:*_____ *Relationship:*_____

*Name:*_____ *Relationship:*_____

*Name:*_____ *Relationship:*_____

*Name:*_____ *Relationship:*_____

Name (please print):_____

Signature:_____ Date:_____/_____/_____

If the client is a minor, the legal guardian must sign the statement below.

I affirm that I am the legal guardian of (client's name):_____ with the total understanding of the above mentioned.

_____	_____	_____/_____/_____
Legal Guardian's Name	Legal Guardian's Signature	Date