Susan Myket, Ph.D. & Associates

Using Research-Supported Therapies to Enrich Families

Office Use Only:
DX: _____
☐ Copy 1st page
☐ Fax to NSB

ADULT INTAKE FORM

(Please Print)

Today's Date	Appt. With	Whom may we thank for referring you?

CLIENT INFORMATION

Last Name, First Name, Middle Initial	Birth Date	☐ Male ☐ Female

Street Address	City	State	Zip Code

Preferred Phone #	☐ Cell ☐ Landline	Confidential Msg/Txt ☐ Yes ☐ No	Alternate Phone #	☐ Cell ☐ Landline	Confidential Msg/Txt ☐ Yes ☐ No

Email Address	**I give permission to send the following to my email address:** Group Therapy Info (approx. each quarter) & Practice Updates. ☐ Yes ☐ No Appointment Information if we can't reach you by phone. ☐ Yes ☐ No Updated Privacy Notices ☐ Yes ☐ No

Employer's Name, Address, and Work Phone (Confidential VM ☐ Yes ☐ No)

If someone else answers your phone, with whom may we leave a verbal message about your appointment scheduling?
With whom may we discuss billing?

Anything else you'd like us to know about communicating with you or your family

Referring Doctor (if required by insurance)	Phone:	Notify of your visit? ☐ Yes ☐ No

Primary Care Physician (if different from referring Dr.)	Phone:	Notify of your visit? ☐ Yes ☐ No

IN CASE OF EMERGENCY

Last Name, First Name, Middle Initial	Relationship to you

Preferred Phone #	☐ Cell ☐ Landline	Confidential Msg/Txt ☐ Yes ☐ No	Alternate Phone #	☐ Cell ☐ Landline	Confidential Msg/Txt ☐ Yes ☐ No

Employer's Name and Work Phone (Confidential VM ☐ Yes ☐ No)

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ADULT INTAKE FORM CONTINUED

PRIMARY INSURANCE INFORMATION		
Insured's Last Name, First Name, Middle Initial		Birth Date
Insurance Company	Phone Number	
Insurance Billing Address		
Policy No.	Group No.	Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
SECONDARY INSURANCE INFORMATION (IF APPLICABLE)		
Insured's Last Name, First Name, Middle Initial		Birth Date
Insurance Company	Phone Number	
Insurance Billing Address		
Policy No.	Group No.	Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent

The above information is true to the best of my knowledge. I authorize Susan Myket, Ph.D. & Associates to use and disclose my private health information for treatment, payment, and health care operations. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. Furthermore, I have reviewed the Notice of Privacy Practices and Client Information Brochure provided. I fully understand and accept the terms of this practice. I have had the opportunity to ask questions which clarify the conditions under which I consent to treatment and give my permission to Susan Myket, Ph.D. & Associates to provide me with evaluation, testing, consultation, and/or psychotherapy.

_____

Signature Date

Authorization to Secure Payment

I, _____ authorize Susan Myket, Ph.D. & Associates to process payments on my Credit Card for copays, co-insurance, or deductibles after each service and again if any balance is due once insurance has processed my claims. I understand that charges may be made on a date other than the actual date of service. **These charges may come from NetSource Billing, LLC.** I further understand that if I miss a scheduled appointment and fail to provide 24 hours advance notice, the full amount of the session will charged to my credit card. I have read and understand this authorization to secure payment.

If you plan to email this document, please only sign your name. Card information will be entered by our staff.

My credit card information is as follows:

_____

Signature of Card Holder Today's Date

_____ _____

Name on Credit Card Client's Name

_____ _____ _____ _____

Credit Card Account Number Expiration Date 3-4 Dig. Sec. Code Zip Code of CC Billing Address

Is this a debit card? ☐ Yes ☐ No Is this an HSA card? ☐ Yes ☐ No