Susan Myket, Ph.D. & Associates

Using Research-Supported Therapies to Enrich Families

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

CHILD/ADOLESCENT INTAKE FORM

(Please Print)

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

CLIENT INFORMATION

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

Street Address	City	State	Zip Code

Client Lives with

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

PARENT/GUARDIAN RESPONSIBLE FOR ACCOUNT

Last Name, First Name, Middle Initial	Birth Date

Billing Address if different than client's	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)

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

PARENT/GUARDIAN # 2

Last Name, First Name, Middle Initial	Birth Date

Address if different than client's	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)

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CHILD/ADOLESCENT 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.	Client Relationship to Insured ☐ Self ☐ 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.	Client Relationship to Insured ☐ Self ☐ 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 evaluation, testing, consultation, and/or psychotherapy for myself or my child/family.

_____

Parent/Guardian Signature Date

_____

12-17 Year Old Client Signature – I understand my privacy rights & terms of the practice and I consent to treatment. 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