Susan Myket, Ph.D & Associates

Licensed Clinical Psychologists
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- Required	**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 Bill Notices/Receipts ❑ 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 Bill Notices/Receipts ❑ yes ❑ No

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

1415 Bond Street, Suite 127, Naperville, Illinois 60563
(630) 355-9002 x 315 (630) 355-9012 (F)
Intake@myketandassociates.com

Susan Myket, Ph.D. & Associates
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-Required

It is the policy of Susan Myket, Ph.D. & Associates to have a credit card on file.
I, _____ authorize Susan Myket, Ph.D. & Associates to process payment on my Visa, MasterCard or Discover for any balance due that has not been paid **30 days after my bill is received. These charges will appear from NetSource Billing, LLC.** I understand that if my card is declined, Susan Myket, Ph.D. & Associates may put my payment through on another day when funds become available. I further understand that if I miss a scheduled appointment and fail to provide 24 hours advance notice, I will be billed the full amount of the session and my credit card will be charged per the statement above. I understand that I have given Susan Myket, Ph.D. & Associates my Credit Card information. I have read and understand this authorization to secure payment.

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

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