(THIS BOX IS FOR OFFICE USE ONLY)

DX CODES~FOR VERIFICATION: _____

CPT CODES~FOR VERIFICATION: ☐*90791* ☐*96101* ☐*96118* ☐*OTHER*_____

NEW PATIENT INTAKE FORM

Jennifer Gale Psy.D.
Gale & Associates Center for Assessment and Psychotherapy PLLC
2760 W Rasmussen Road D205 Park City UT 84098
(& Mental Health Management Inc.)

PATIENT INFORMATION

(PLEASE PRINT CLEARLY)

Name:_____ Age:_____ DOB_____/_____/_____ Sex: M / F

Street address: _____

City:_____ State:_____ Zip:_____

Home Phone: ( )_____-_____ Emer. con. Ph: ( )_____-_____

Emergency contact name: _____

Chief complaint (specific reason for your visit):_____

_____

*RESPONSIBLE PARTY INFORMATION *PLEASE READ: If the patient is a minor, and his/her parents are separated, we will only bill one party, and that party must sign the attached financial agreement.*

Name:_____ DOB_____/_____/_____ Sex: M / F

Street address to send billing:_____

City:_____ State:_____ Zip:_____

Hm. ph.:( )_____-_____ Wk:( )_____-_____ Mob:( )_____-_____

Email address:_____

S.S.#_____-_____-_____ Marital status:_____ Relation to patient:_____

Employer:_____ Empl. Ph:( )_____-_____

INSURANCE INFORMATION *(Please enter hand written information, as well as presenting your ins. card)*

Primary insurance:_____ Ph # for Mental Health:( )_____-_____

Subscriber name:_____ SS #_____-_____-_____ DOB:_____/_____/_____

Relation to Client:_____ ID/Membership #_____ Group # _____

Secondary insurance: _____Ph # for Mental Health:( )_____-_____

Subscriber name:_____ SS #_____-_____-_____ DOB:_____/_____/_____

Relation to Client:_____ ID/Membership #_____ Group # _____

I hereby authorize Jennifer Gale Psy.D. to release any information, requested by the above-named insurance companies, that is needed to process claims, and to pay directly to Jennifer Gale Psy.D., any insurance benefits. I hereby authorize Jennifer Gale Psy.D. to release any information requested by *Mental Health Management*, Inc, which is needed to bill the above-named insurance co. and/or responsible party directly. In addition, I also authorize Jennifer Gale Psy.D. and *Mental Health Management*, Inc to send clinical or billing communications via my email address, if I have provided it on this New Intake Form. I affirm the above information to be true and correct, and give my consent for treatment. I understand that I am entitled to a copy of this agreement.

Signature_____ Date: _____/_____/_____

PATIENT/ GUARANTOR FINANCIAL AGREEMENT

Jennifer Gale Psy.D.
Gale & Associates Center for Assessment and Psychotherapy PLLC
2760 W Rasmussen Road D205 Park City UT 84098
(& MHM Billing Services)

INSURANCE COVERAGE AND BENEFIT INFORMATION-

If you would like information about your estimated financial obligation for services, please contact my billing agent, *Mental Health Management*, Inc. at 801-562-4484. As a courtesy to you, my billing service will verify your insurance coverage and benefits. However, I encourage you to call your insurance company, and re-verify your coverage and benefits. *Please be aware that verification of insurance coverage and benefits, is not a guarantee of insurance payment, and coverage/benefits are frequently quoted incorrectly.* Keep in mind that some procedures will not be covered at all, even if your insurance company has quoted coverage for those procedures. You will be responsible for payment in full if your insurance company does not pay, *or*, if your insurance company does not pay in a timely manner. All patients, who are required to seek reimbursement for my services through their insurance company, will be expected to pay for services in full at the time of service, unless prior arrangements are made. My billing service will then submit claims on your behalf, so that you may be reimbursed by your insurance company. However, this is not a guarantee that your insurance company will reimburse you as they quoted.

ACCEPTANCE OF TERMS OF FINANCIAL RESPONSIBILITY-

(Please read the following financial terms and conditions carefully, and if you agree, please sign and date each one. Thank you!)

1.) MISSED APPOINTMENTS:

I (the undersigned) understand that if I will not be able to come to an appointment, I am required to give a full **48** hours prior notice of cancellation. I understand that prior notice of cancellation is required to be given Mon.-Fri., between the hours of **8am** and **4pm.** In the event that I do not give said notice, I specifically agree to pay a fee for the missed appointment in the amount of **$200.00.** I understand that it is my financial obligation to pay this fee within two weeks of the missed appointment date. I understand that by signing below, I agree to the terms and conditions listed above.

_____ _____

Signature Date

2.) RETURNED CHECKS:

I (the undersigned) understand that in the event that there is a returned check, I specifically agree to pay a $35.00 returned-check fee, in addition to the original payment amount, due within 2 weeks of the original payment date. I understand that by signing below, I agree to the terms and conditions listed above.

_____ _____

Signature Date

3.) RECOVERY OF INCURRED CHARGES:

I (the undersigned), understand that once my account is 30 days late, I will pay a **5%** monthly finance charge. I understand that this charge is a billing service charge, and cannot be removed once it has been applied. I also understand that If my account reaches 90 days past due, it may be immediately turned over to a collection agency. If the account is referred to a collection agency or attorney for collection, I further agree to pay an additional amount representing fifty percent (60%) of the principal balance. This additional amount is in recognition of the costs associated with said collection action processing. In the event legal action is taken to collect on the account, I also specifically agree to pay all reasonable attorney's fees and court costs. I understand that by signing below, I agree to the terms and conditions listed above.

_____ _____

Signature Date