

THIS BOX IS FOR OFFICE USE ONLY

DX: _____

Psychotherapy

Psychological Testing

INTAKE FORM

C. Maxwell Gale, Psy.D. & Walker Billing Services

CLIENT INFORMATION

(PLEASE PRINT CLEARLY)

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

Street address: _____

City: _____ State: _____ Zip: _____

Email: _____ Hm. ph.: () _____ - _____ Cell Phone: () _____ - _____

Emergency contact name and phone number _____

Chief complaint (specific reason for your visit): _____

RESPONSIBLE PARTY INFORMATION (If different than above)

Name: _____ DOB _____ / _____ / _____ Sex: M / F

Street address to send billing: _____

City: _____ State: _____ Zip: _____

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

Email address: _____

Marital status: _____ Relation to patient: _____

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

INSURANCE INFORMATION

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

Subscriber name: _____ DOB: _____ / _____ / _____

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

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

Subscriber name: _____ DOB: _____ / _____ / _____

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

I hereby authorize C. Maxwell Gale, to release any information, requested by the above-named insurance companies, that is needed to process claims, and to pay directly to C. Maxwell Gale, any insurance benefits. I hereby authorize C. Maxwell Gale, to release any information requested by *Walker Billing Services*, which is needed to bill the above-named insurance co. and/or responsible party directly. In addition, I also authorize C. Maxwell Gale and *Walker Billing Services*. 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:** _____ / _____ / _____