Gale & Associates Center for Assessment and Psychotherapy PLLC
2760 W Rasmussen Road D210 Park City, UT 84098
Office Phone: 435-645-9240 Fax: 866-376-8067

NEW PATIENT INTAKE FORM

Date:

CHILD INFORMATION

First: _____ Last: _____ Pronouns: _____
Address: _____ City: _____ State: UT Zip: _____
DOB: _____ Age: _____ Gender: Male ○ Female ○ Other ○
Chief Complaint: (specific reason for you visit):

PARENT/GUARDIAN INFORMATION

First: _____ Last: _____
Address: _____ City: _____ State: UT Zip: _____
Phone: _____ Alt. Phone _____ Email: _____
Relationship to client: _____ Marital Status: _____

2nd PARENT/GUARDIAN INFORMATION

First: _____ Last: _____
Address: _____ City: _____ State: UT Zip: _____
Phone: _____ Alt. Phone: _____ Email: _____
Relationship to client: _____ Marital Status: _____

EMERGENCY CONTACT

First: _____ Last: _____
Address: _____ City: _____ State: UT Zip: _____
Phone: _____ Email: _____ Relationship to client: _____

NOTE: If the patient is a minor, and there is one custodial parent, we will only bill one party, and that party must sign the attached financial agreement.

Do you have insurance that you would like us to bill? ○ Yes ○ No
If so, the CPT verification codes to provide to your insurance are listed here:

CPT CODES FOR VERIFICATION:	90791	96132 / 96133	96136 / 96137	96130/31

PRIMARY INSURANCE INFORMATION

Provider: _____ Ph# for Mental Health: _____
Member ID #: _____ Group #: _____
Employer: _____
Subscriber's name: _____ DOB: _____

SECONDARY INSURANCE INFORMATION

Do you have secondary insurance? ○ Yes ○ No
Provider: _____ Ph# for Mental Health: _____
Member ID #: _____ Group #: _____
Employer: _____
Subscriber's name: _____ DOB: _____

I hereby authorize Gale&Associates 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 *Wasatch Billing Innovations*, 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 *Wasatch Billing Innovations*, 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 Parent/Guardian: Date:

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PATIENT / GUARANTOR FINANCIAL AGREEMENT

INSURANCE COVERAGE AND BENEFIT INFORMATION-

If you would like information about your estimated financial obligation for services, please contact our office. If your billing is being handled by our billing agent, *Wasatch Billing Innovations* (801-707-1810) we will refer you to them. As a courtesy to you, if Dr. Gale or Dr. Soutor is in-network with your insurance plan, we will verify your insurance coverage and benefits. However, we encourage you to call your insurance company, and re-verify your coverage and benefits. If we are not in network with your plan, you will be responsible for payment in full at the time of services, unless prior arrangements are made. We will submit claims on your behalf, or if preferred, we can provide you with a master bill that you can submit to your insurance company, so that you may be reimbursed by your insurance company directly. This is not a guarantee that your insurance company will reimburse you as they quoted. If our office is reimbursed after you have made payment, we will refund you via your original method of payment. *Please be aware that verification of insurance coverage and benefits, is not a guarantee of insurance payment, and coverage/benefits are often misquoted.* 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, which we define as 3 to 6 months from the time that claims are submitted.

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 Parent/Guardian: _____ 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 Parent/Guardian: _____ 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 Parent/Guardian: _____ Date: _____