C. Maxwell Gale, PSY.D
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 CLIENT INTAKE FORM - MINOR

Date:

CLIENT INFORMATION

Name: _____ Pronouns: (if relevant to identify) _____
Address: _____ City: _____ State: UT Zip: _____
DOB: _____ Age: _____ Gender: Male ○ Female ○ Other ○

PARENT/GUARDIAN INFORMATION

Name: _____
Address: _____ City: _____ State: UT Zip: _____
Cell: _____ Email: _____
Can voicemails be left referencing therapy? ☐ Yes ☐ No
Can texts be exchaned regarding session scheduling? ☐ Yes ☐ No
Can emails be sent regarding therapy? ☐ Yes ☐ No
Does another parent/guardian that possess custody/guardianship? ☐ Yes ☐ No

2nd PARENT/GUARDIAN INFORMATION

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell: _____ Email: _____

I CONSENT FOR C. MAXWELL, PSY.D. TO CONTACT THE FOLLOWING PERSON IN THE EVENT OF AN EMERGENCY:

EMERGENCY CONTACT

Name: _____ Phone: _____
Email: _____ Relationship to client: _____

ACCOUNT MANAGEMENT

Name of head of household managing records for services rendered: _____

Option 1: Discounted (i.e., $10 when paying within 24hrs of your appointment by):

Cash ☐ Check ☐ Bank Transfer ☐ (e.g. Zelle, pay to max@summitprogroup.com)

Option 2: Payment by credit card (does not qualify for discount, card will be kept on file):

Cardholder Name: _____ Credit Card #: _____
Exp. Date: _____ Security Code: _____ Billing Zip: _____
Email (to obtain receipt of payment: _____

INSURANCE INFORMATION

Provider: _____ Ph# for Mental Health: _____
Member ID #: _____ Group #: _____
Employer: _____
Subscriber's name: _____ DOB: _____
Relation to client: _____ Co-pay: _____

My signature indicates the information is correct and authorize C. Maxwell Gale to share information with his office manager. My signature indicates I consent to the methods of C. Maxwell Gale contacting me as indicated as well as for C. Maxwell Gale to contact my emergency contact name in an event deemed an emergency by C. Maxwell Gale. In the circumstance I am asking C. Maxwell Gale to bill insurance I consent for him 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 affirm the above information to be true and correct, and give my consent for it's use in the process of treatment/assessment. I understand that I am entitled to a copy of this agreement.

_____ _____
Parent/Guardian Signature: Date: