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 - RELATIONSHIP

Date:

CLIENT INFORMATION

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

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

EMERGENCY CONTACT

Name: ______ Phone: ______

CLIENT INFORMATION

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

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Can texts be exchaned regarding session scheduling? ☐ Yes ☐ No
Can emails be sent regarding therapy? ☐ Yes ☐ No

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

EMERGENCY CONTACT

Name: ______ Phone: ______

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.

______ ______
Client Signature: Date:

______ ______
Client Signature: Date: