Patient Intake Form

Note: in the case of divorced parents, the parent signing this form is considered ultimately responsible for all fees.

Patient Information

Patient name _____ Date of birth _____ M F

Address _____ City _____ Zip _____

Parent's names (if minor) _____ Cell phone: _____

Second phone: _____ Email: _____

Reminder preference: Text Email 1 of each

Pharmacy: phone _____ Name and address: _____

In case of emergency, who should be notified? _____ Phone _____

Insurance Information

Primary person covered under insurance _____ Date of birth _____

Relationship to patient: _____Soc. Sec. #_____ Phone _____

Address (if different from pt): _____ City, state _____ Zip _____

Insurance Co. for mental health_____ Ins. ID No. _____

Ins. Co. phone_____ Employer/ Occupation _____

*We bill only to primary insurance carrier. We will be happy to furnish receipts and explanation of benefits to help you submit to secondary carrier.

I, the undersigned, certify that I (or my dependent) have insurance coverage as listed above and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I have read, I understand, and I agree to the Patient Financial Agreement and Notice of Privacy Practices. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize Danielle Putrow, PsyNP to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

I consent to the use of HIPAA compliant telepsych (video and sound) services when appropriate to my care.

I give Danielle Putrow, PsyNP permission to treat and prescribe medication for myself/ my dependent.

Printed name _____ Signature _____ Date _____

CHANGES/ UPDATES TO ABOVE (including date and patient initials):