Katharyn Waterfield, LPC
OBLPCT Lic #C4802
Intake Form 2020

Patient Information

Name _____

Age _____ Patient Date of Birth _____ / _____ / _____
Height _____'_____" Gender _____
Relationship Status _____

Home Address

Street _____

City _____ State _____ Zip _____

Cell Phone (_____) _____
May we leave a message? Yes [ ] No [ ]

Home Phone (_____) _____
May we leave a message? Yes [ ] No [ ]

Work Phone (_____) _____
May we leave a message? Yes [ ] No [ ]

Email _____
May we use this email to send messages? Yes [ ] No [ ]
May we use this email for reminders? Yes [ ] No [ ]

Please be aware that email may not be confidential.

Emergency Contact Name_____

Emer. Ct Phone number #_____

Emergency Contact Relationship to Patient_____

Person Responsible for Payment_____

Relationship to Subscriber: Self [ ] Spouse/Partner [ ] Child [ ]

Home Phone _____

Address _____

Primary Insurance

Private Pay [ ]
Name of Insurance Company:
_____

Ins. Phone (_____) _____

Subscriber

Name _____
Address _____
_____

Patient Relationship to Subscriber
Self [ ] Spouse/Partner [ ] Child [ ]

Subscriber's Date of Birth
_____ / _____ / _____
Subscriber's Gender _____

Member ID # _____
Group # _____

Provider will fill in below this line

Payment method for services
Check [ ] Credit card[ ] HSA[ ] Cash[ ]
Provider is In-Network? Yes [ ] No [ ]

Patient fee 90791 $_____
Patient fee 90834 $_____
Patient fee 90837 $_____
Patient fee 90845 $_____
Other _____ $_____
Other _____ $_____
Co-pay/Co-Ins. amt.$_____
Deductible Amount $_____

Secondary Insurance

Insurance Name
_____

Ins. Ph. (_____) _____

Subscriber

Name _____
Address _____
_____

Patient Relationship to Subscriber
Self [ ] Child [ ] Spouse/Partner [ ]

Subscribers Date of Birth
_____ / _____ / _____
Subscribers gender _____

Member ID # _____
Group# _____

Medications & Supplements

_____
_____
_____
_____

Allergies

_____
_____
_____

ICD 10

- I am responsible for payment for services.
- I authorize the release of any health information necessary to process insurance claims for services. This release of information expires **December 31, 2022.**
- I authorize my insurance company to pay medical benefits to the provider of services. I understand that I am fully responsible for all professional fees not covered by this assignment.
- I was offered a copy of the HIPAA notice and Office Polices.
- Unless paid for by check or cash at the beginning of an appointment, I authorize the use of my credit or debit card to pay the balance of my fees.
- I understand that payment is due at the time of service unless prohibited by the providers contract with insurer.

Signature _____ **Date** _____

Revised 2.3.2020