Tami Applegate MS, MFT

Licensed Marriage and Family Therapist

CLIENT INTAKE FORM

Today's Date:_____

CLIENT INFORMATION

Client's Last Name **First** **Middle** **Date of Birth** **Age**

Social Security Number **Email Address** **Cell Phone**

Occupation **Employer** **Home Phone**

Street Address **City** **State** **Zip code**

Name of Significant Other **Relationship Status** **Length of Relationship**

Number of Children **Ages**

Referred By: circle **Website Google** **Psychology Today** **Insurance**
Friend/Family:_____ **Doctor:_____**

INSURANCE INFORMATION

please provide a copy of your insurance card front and back

Primary Insurance

Name of Insured **Insured's Date of Birth** **Employer**

Insurance Company **ID/Policy#** **Group #**

Secondary Insurance

Name of Insured	**Insured's Date of Birth**	**Employer**
Insurance Company	**ID/Policy#**	**Group #**

PLEASE READ THE FOLLOWING CAREFULLY:

I hereby consent to treatment by Tami Applegate MFT. I authorized the release of any necessary medical information for insurance reimbursement purposes and authorize the payment of medical benefits to Tami Applegate. I understand that insurance is billed as a courtesy and I am financially responsible for any unpaid balances such as co-payments, deductibles, and claims denied by my insurance company.

Client/Guardian Signature **Date**

Cancellations and Missed Appointments:

Appointments are reserved solely for you and often cannot be filled with another client if you don't provide 24 business hours notice. You will be charged $80.00 on your Credit Card on file for sessions that you cancel with less than 24 business hours notice. Monday appointments must be cancelled on the prior business day, usually a Friday. You may leave a voicemail message on my phone 24 hours a day. Insurance companies generally do not reimburse for missed appointments.

Unmet Copayments and Deductibles, and Balances:

You are responsible for understanding the limits and exclusions of your health insurance. If for any reason your insurance claim is denied, you will be charged the full reimbursement amount for dates of service. Additionally, if there are any unpaid balances after 30 days, the credit card will be charged to cover these expenses. By signing this form, you agree that any balance due is your responsibility and your credit card will be charged.

Type of Card: _____

Name as It Appears on the Card: _____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Your Billing Address :_____

City/State/Zip Code: _____

Phone number with area code: _____

Your signature below indicates that you have read, understand and agree to the above statements and give permission to have your credit card on tile charged for any of the above unmet expenses.

Signature Date