Etheridge PSYCHOLOGY
Assessment and Psychotherapy

115 Kildaire Park Dr Ste 313, Cary, NC 27518
tel 919.600.4906 fax 888.887.6361
www.etheridgepsychology.com

INITIAL INTAKE FORM

Patient's First & Last Name:		Birthdate:	
Parent or Legal Guardian Name (if applicable):			
Referred By (e.g. self, name of doctor):			

Please provide the address to which any documents, including billing statements and clinical information, may be sent. Our practice name and address appear on our envelopes.					
Address:		City:		Zip:	

Please only list phone numbers for which you give us permission to leave a message for you, whether with the person who answers or on your voice mail.	Home:	
	Cell:	

Who should we contact in the event of an emergency?	Name:			
	Phone:		Relationship:	

Primary Physician:		If you want a copy of your record sent to your primary care physician, please ask to complete a release form.

The following information is only to be completed by patients using health insurance:

Many insurance companies require that we obtain this additional demographic information:					
Gender:		Race:		Marital Status:	
Occupation:		Work Phone:			

Unless you are paying <u>in full</u> on the date of your appointment, social security number of the patient (or the legal guardian signing the consent for this patient) is <u>required</u>.			
Social Security Number of patient (or legal guardian):			
Is this the patient's SSN?	○ yes ○ no	If not, please list full name:	

This section refers to the **primary subscriber** or **primary cardholder** on your health insurance plan. Leave blank if you are the primary subscriber.					
Name:		Birthdate:		Phone:	
Address:		City:		Zip:	
Patient's relationship to this person:	○ spouse ○ child or other dependent				

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PSYCHOLOGICAL SERVICES AGREEMENT

Please initial next to each item indicating your agreement to each statement:

_____ I have read the **Informed Consent for Psychological Services** and agree to abide by its terms.
(initials)

_____ I have read the **Financial Policies** and agree to abide by its terms.
(initials)

_____ I have been presented with the **HIPAA Privacy Notice**.
(initials)

If you are using health insurance:

_____ I understand that I am responsible for any portion of my balance not covered by my insurance. I agree to pay any balance remaining after my insurance claim is finalized, and I understand that I will need to discuss any remaining balance with my insurance company, not Etheridge Psychology.
(initials)

_____ I agree to allow the disclosure of any necessary medical information about me to my insurance company to process my claim and to assign insurance payment(s) for these services to Etheridge Psychology, P.A.
(initials)

Your signature below indicates that you understand all the policies of our practice and agree to abide by them. We are happy to give you a paper copy of the Informed Consent, Financial Policies, and/or Privacy Notice to take with you if requested.

_____
Printed name of patient

_____ _____
Signature of patient (or legal guardian) Date

Note: If you are signing as a legal guardian of the patient, you affirm that you have the legal right to independently make medical decisions for the patient. If you do not, or another party must also agree to treatment or evaluation, we must obtain that person's signed consent prior to services being rendered.

_____
Printed name of legal guardian (if applicable)