Elaine Maronick MA, LCPC ***Intake Form***

Name:_____ Telephone (home):_____
Last First M.I. (cell)_____

Home Address:_____ _____ _____ _____
Street City State Zip

Birth Date:___/___/___ Soc. Sec.#_____ Referred by:_____

Employer_____occupation_____Telephone_____

Spouse/Partner: _____ occupation _____Telephone:_____

E-mail address_____ Permission to e-mail you? Yes No

Primary Insurance Carrier:_____

Address:_____ _____ _____ _____
Street City State Zip

Policy ID #_____Group # _____

Primary Insurer's Name _____ Soc. Sec. # _____Birthdate: ____/____/___
**Please bring your card to the first session, or provide a copy of both sides of it.*

FINANCIAL POLICY

If you have medical insurance that provides coverage for mental health counseling, I am happy to help you receive your maximum allowable benefits. I accept assignment for benefits (get reimbursed from insurance companies). I am happy to process your insurance claim and expect to only be paid at the time of service for your part of the claim. Please be familiar with the terms of your insurance coverage and status of deductible when you arrive. If you are not familiar with the status of your policy, please be prepared to pay the full fee at time of service.

PLEASE NOTE: A contract of insurance exists between YOU and YOUR INSURANCE COMPANY regarding payment of fees. A contract for service exists between YOU and ME. You are responsible for timely payment for services. A 24-hour cancellation notice is appreciated. In the event of a NO Show or a cancellation within 24 hours of your appointment time, the usual fee will be charged. If you or I am able to fill the hour, a fee will not be charged, otherwise you will be billed for the time booked. *If you do not plan to use insurance, full payment is due at the time of service. Please ask about cash discount if you are interested.*

Signed_____ Date_____

Signed_____ Date_____

******PLEASE TURN PAGE OVER, READ AND SIGN AT BOTTOM******