Sivan Rose Elefson, LMHC, R-DMT | dance/movement psychotherapist
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Confidential Intake Form:

A. PERSONAL INFORMATION:

Patient Name: ____

Date of Birth: ____________________

Address: ____

City/State/Zip: _____________________________________

Email: _________________________

Home Phone: ( ) ____________________ Can I leave a message at this #?: Y / N

Cell Phone: (_____) _________________ Work Phone: (____) ___________________

Preferred method of contact for scheduling change/notification:

Cell ___ Email ___ Home ___ Work ___

Social Security Number: _________________________

Emergency Contact Person: _______________________ Phone: (____) ____________

Primary Care Physician: ____________________ Office Phone: (____) ____________

Is there anything that you would like the therapist to know about your current situation or your goals for therapy? ____

B. INSURANCE INFORMATION:

Primary Insurance Company and ID#: ___________________________

Group # (if applicable): ____

Name of Insured (if different from patient): ____________________ DOB: ___/___/___

Authorization Number for this session: ____________________________________

Secondary Insurance Company and ID#: ___________________________________

Group # (if applicable): ____

Name of Insured (if different from patient): _____________________ DOB: ___/___/___

C. RESPONSIBLE PARTY: Fill in if under 18 or if someone other than patient is responsible for payment:

Name: ____

Address: ____

City/State/Zip: ____

Home Phone: (____) ________________ Business Phone: (____) __________________

Relationship to Patient: ____

Second Responsible Party: ____

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR INSURANCE:

I authorize the use of disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Signed: ____

I authorize payment of medical benefits to my provider for services performed.

Signed: ____ Date: ______________

FINANCIAL POLICY

Appointment cancelled with less than 24 hour notice will be charged to me at the full fee per session of $120.00 per individual, $130.00 for couples, and $150.00 for family therapy sessions.

I am responsible for the entire balance of services performed regardless of whether there is insurance coverage. Secondary insurance will be billed as a courtesy.

I understand and agree to the above stated financial policy.

Signed: ___________________________________ Date: ___________________