KATIE TANDON, LPC

THERAPY INTAKE FORM

Today's Date: _____

Patient Name: Last _____ First _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: (_____) _____ -_____ Cell phone: (_____) _____-_____

Date of Birth: ____/____/____ Age: _____ Sex: (M or F)

E-mail address: _____

Employed: PT FT RET NOT Marital Status: Single Married Divorced Widowed Separated
(Circle all that apply above)

Employer or School Name: _____

Occupation: _____

Work phone: (_____) _____-_____

Primary Care Physician: _____ Phone: _____

In case of emergency, contact:

Name: _____ Relationship: _____

Home phone:(_____) _____ - _____ Work phone: (_____) _____ -_____

INSURANCE COMPANY INFORMATION

Primary Insurance Company: _____

Patient's Relation to Insured: __ Self __ Spouse __ Child __ Other

Policy Holder's Name (if not self): _____ Date of Birth_____

Policy Number: _____ Group Number: _____

I certify that all information stated on this form is correct to the best of my knowledge.

_____ _____
Patient Signature Date

KATIE TANDON, LPC

Authorization For Release Of Medical Information To The Insurance Carrier And Assignment Of Benefits To Physician.

COMMERCIAL INSURANCE

I hereby authorize release of medical information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO: Katie Tandon.
I understand that I am financially responsible for any balance not covered by my insurance carrier.
A copy of this signature is as valid as the original.

Signature of Patient or Guardian: _____

OFFICE USE ONLY_____
DX:
Benefit:

In order to comply with specific rules regarding HIPAA (Health Insurance Portability & Accountability Act of 1996), we ask that our patients review and sign a privacy and security health information document.

It is the office policy of Katie Tandon to not release confidential and/or unauthorized information by home telephone, answering machine, work phone, voicemail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name and telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I authorize Katie Tandon to leave medical information pertaining to my care by the following methods and will assume responsibility to notify her whenever this information changes:

Home Telephone	____Yes	____No	____N/A
Work Telephone	____Yes	____No	____N/A
Cell Phone and/or voice mail	____Yes	____No	____N/A

Will you allow Katie Tandon to leave a message regarding an appointment rescheduling or confirmation?
Home____ Work____ Cell____ E-mail___

ACKNOWLEDGEMENTS

I understand Katie Tandon's Policy that:

1. 24 hours' notice is required for a cancellation otherwise a $60 fee will be charged for the missed appointment.
2. Checks returned for any reason from the bank will carry a $35 fee.

X_____ X_____
Client Date

X_____ X_____
Parent/Guardian Date

X_____ X_____
Witness Date

KATIE TANDON, LPC

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of Katie Tandon.

Print Name of Patient: _____

Signature of Patient: _____ Date: _____

Signature of Personal Representative: _____ Date: _____

Katie Tandon, LPC (Privacy Officer): _____ Date: _____