Human Development Associates, LLC

Client Intake Form

Today's Date: Date of Birth: Gender: M / F

First Name: Middle Initial: Last Name:

Marital Status: Email:

Address 1: Address 2:

City: State: Zip:

Home Phone: Cell Phone:

Work Phone: Other Phone:

Referred by:

Type of Insurance

MEDICARE	MEDICAID	RICARE CHAMPUS	CHAMPVA
GROUP HEALTH PLAN		FECA BLK LUNG	OTHER

Insured's ID:

Insurance Policyholder Information

First Name: Last Name: Date of Birth: Gender: M / F

Address: City: State: Zip

Phone: Relationship to Patient:

Employer or School Name:

Plan Name: Policy or Group Number:

Other Insurance Coverage

First Name: Last Name: Date of Birth: Gender: M / F

Employer or School Name:

Plan Name: Policy or Group Number:

Fee Agreement

Fees are for a 50-minute hour, e.g. 12.5 minutes is one-fourth of the hourly rate. Times less or more than one hour will be billed in quarter-hour increments. **If you are late for an appointment, your session will be limited to the remainder of the scheduled time.**

Assessment Fee	$275 per hour
Therapy Fee	$225 per hour

Payment Options

Please check one:

_____Health Insurance: HDA will submit a claim to your primary health insurance carrier. You will receive a mental health diagnosis that will be submitted with your insurance claim. If you need a referral or pre-certification from your insurance company, you are responsible for obtaining that. You are personally responsible for any amount not covered by your insurance.

_____Private Payment: You will receive a bill on a monthly basis. The balance is payable monthly except by special arrangement.

Discount for Same-Day Payment:

If you pay for service on the day of your appointment with cash, check or credit card, the fee for Assessment is $175 and any subsequent hour of therapy after, $150. We are able to offer this discount because we save substantially on billing costs. If your session is not paid for on the day of service, we will bill you privately at the regular rate. If you choose the discount, we cannot go back and bill your insurance company later for that service. Upon request, your therapist can provide you a form that includes a diagnosis and procedure code that would allow you to access your HSA or FSA account.

Failure to comply with payment of services is subject to collection and credit reporting.

Missed Appointment:

We request that appointments be cancelled 24 hours in advance except in emergency. If you fail to give 24 hours' notice or miss an appointment three times during your treatment, you will need to make special arrangements with your therapist before you can schedule another appointment.

Appointment Reminders:

E-mail reminder- By initialing for email reminders you authorize Human Development Associates to contact you via email. You are accepting the limits of confidentiality of email communications, and agree to be contacted via email in the future regarding upcoming appointments.

____ Initial here if you would like an e-mail reminder. Legibly print your e-mail address: _____

Phone reminder- By agreeing to this service you waive confidentiality regarding the time, date and place of your appointment if a message is left.

____ Initial here if you would like a phone message reminder. Phone Number: _____

I understand that by completing this intake sheet, I will be considered a client of HDA and a client record will be developed for me. Each client will receive an assessment. If I choose to use my health insurance, I authorize HDA to furnish to my insurance carrier information regarding services to me or my dependent(s). I assign to HDA all insurance payments made to me or my dependent(s) for psychotherapy services. I understand I am responsible for any fee balance not covered by my insurance company.

Client Signature:

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