

Susan Myket, Ph.D. & Associates

Licensed Clinical Psychologists
Using Research-Supported Therapies to Enrich Families

CLIENT INTAKE FORM

(Please Print)				
Today's Date:	Appt. With:		Whom may we thank for referring you?	
CLIENT INFORMATION				
Last Name, First Name, Middle Initial			Birth Date:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address	City	State	Zip Code	Home Phone No.:
Email Address				
PHONE NUMBER WHERE WE MAY LEAVE A MESSAGE ABOUT CLIENT?				
MOTHER'S INFORMATION (OR GUARDIAN)				
Last Name, First Name, Middle Initial			Birth Date:	Home Phone No.:
Street Address	City	State	Zip Code	Cell Phone No.:
Email Address				
Employer's Name, Address and Work Phone				
FATHER'S INFORMATION (OR GUARDIAN)				
Last Name, First Name, Middle Initial			Birth Date:	Home Phone No.:
Street Address	City	State	Zip Code	Cell Phone No.:
Email Address				
Employer's Name, Address, and Work Phone				

1415 Bond Street, Suite 127, Naperville, Illinois 60563
(630) 355-9002 (P) (630) 355-9012 (F)
www.myketandassociates.com

CLIENT INTAKE FORM CONTINUED

PRIMARY INSURANCE INFORMATION		
Insured's Last Name, First Name, Middle Initial	Birth Date:	Social Security #
Insurance Company	Phone Number	
Insurance Billing Address:		
Policy No.:	Group no.:	Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
SECONDARY INSURANCE INFORMATION (IF APPLICABLE)		
Insured's Last Name, First Name, Middle Initial	Birth Date:	Social Security #
Insurance Company	Phone Number	
Insurance Billing Address:		
Policy No.:	Group no.:	Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. I also authorize Susan Myket, Ph.D. & Associates and the insurance company to release any information required to process my claims. Furthermore, I have reviewed the Notice of Privacy Practices and Client Information Brochure provided. I fully understand and accept the terms of this practice.		
Parent/Guardian Signature	Date	

Authorization to Secure Payment

I, _____ authorize Susan Myket, Ph.D. & Associates to process payment on my Visa or MasterCard for any balance due that has not been paid **30 days after it is received. These charges will appear from NetSource Billing, LLC.**

I understand that if my card is declined, Susan Myket, Ph.D. & Associates may put my Visa or MasterCard payment through on another day when funds become available.

I understand that I have given Susan Myket, Ph.D. & Associates my Visa or MasterCard information. I further understand that if I miss a scheduled appointment or fail to provide 24 hours notice, my credit card will be charged the full amount of the session.

I have read and understand this form. I attest that the information below is true and accurate.

Signature of Card Holder

My credit card information is as follows:

Cardholder's Name

Client's Name

Credit Card Account Number

Expiration Date

Is this a debit card?
 Yes No

Today's Date