Susan Myket, Ph.D. & Associates

Licensed Clinical Psychologists
Using Research-Supported Therapies to Enrich Families

ADULT 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	❑ Male ❑ Female

Street Address	City	State	Zip Code

Preferred Phone #	❑ Cell ❑ Landline	Confidential Msg/Txt ❑ Yes ❑ No	Alternate Phone #	❑ Cell ❑ Landline	Confidential Msg/Txt ❑ Yes ❑ No

Email Address	**I give permission to send the following to my email address:** Group Therapy Info (approx. each quarter) & Practice Updates. ❑ Yes ❑ No Appointment Information if we can't reach you by phone. ❑ Yes ❑ No Updated Privacy Notices ❑ Yes ❑ No

Employer's Name, Address, and Work Phone (Confidential VM ❑ Yes ❑ No)

If someone else answers your phone, with whom may we leave a verbal message about your appointment scheduling?
With whom may we discuss billing?

Anything else you'd like us to know about communicating with you or your family

Referring Doctor (if required by insurance)	Phone:	Notify of your visit? ❑ Yes ❑ No
Primary Care Physician (if different from referring Dr.)	Phone:	Notify of your visit? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Last Name, First Name, Middle Initial	Relationship to you

Preferred Phone #	❑ Cell ❑ Landline	Confidential Msg/Txt ❑ Yes ❑ No	Alternate Phone #	❑ Cell ❑ Landline	Confidential Msg/Txt ❑ Yes ❑ No

Employer's Name and Work Phone (Confidential VM ❑ Yes ❑ No)

Susan Myket, Ph.D. & Associates

ADULT INTAKE FORM CONTINUED

PRIMARY INSURANCE INFORMATION		
Insured's Last Name, First Name, Middle Initial		Birth Date
Insurance Company		Phone Number
Insurance Billing Address		
Policy No.	Group No.	Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
SECONDARY INSURANCE INFORMATION (IF APPLICABLE)		
Insured's Last Name, First Name, Middle Initial		Birth Date
Insurance Company		Phone Number
Insurance Billing Address		
Policy No.	Group No.	Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent

The above information is true to the best of my knowledge. I authorize Susan Myket, Ph.D. & Associates to use and disclose my private health information for treatment, payment, and health care operations. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. Furthermore, I have reviewed the Notice of Privacy Practices and Client Information Brochure provided. I fully understand and accept the terms of this practice. I have had the opportunity to ask questions which clarify the conditions under which I consent to treatment and give my permission to Susan Myket, Ph.D. & Associates to provide me with evaluation, testing, consultation, and/or psychotherapy.

____

Signature   Date

Authorization to Secure Payment

I, ____ authorize Susan Myket, Ph.D. & Associates to process payment on my Visa, MasterCard or Discover for any balance due that has not been paid **30 days after my bill 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 payment through on another day when funds become available. I further understand that if I miss a scheduled appointment and fail to provide 24 hours advance notice, I will be billed the full amount of the session and my credit card will be charged per the statement above. I understand that I have given Susan Myket, Ph.D. & Associates my Credit Card information. I have read and understand this authorization to secure payment.

My credit card information is as follows:

____

Signature of Card Holder   Today's Date

____

Name on Credit Card

____

Client's Name

____

Credit Card Account Number

____

Expiration Date

____

3-4 Dig. Sec. Code

____

Zip Code of CC Billing Address

Is this a debit card? ☐ Yes ☐ No