Boston Evening Therapy Associates, LLC
7 Kent Street
Brookline, MA 02445
(617) 738-1480
www.bostoneveningtherapy.com

Initial Intake Information

Name:_____ Date of Birth:_____
Social Security Number: _____ ☐Male ☐Female
Address: _____
City/State/Zip: _____
Cell Phone: _____ Other phone: _____
Email address: _____
Preferred means of Communication: Cell☐ Call Work☐ Call Home☐
☐Email
Primary Care Physician: _____Office Phone: _____
Emergency Contact: _____ Phone: _____
Relationship: _____

Insurance
Primary Insurance Company: _____
Address: _____
City/State/Zip: _____
Phone: _____
Name of Insured if Different from Client: _____DOB: ____
Insurance ID #_____ Group # _____

Secondary Insurance Company: _____
Address: _____
City/State/Zip _____
Name of Insured if Different from Client: _____DOB: ____
Insurance ID #_____ Group # _____

Insurance Coverage Information
Annual Deductible: _____
Insurance Coverage Per Session 100% 80% 50% Other: _____
How much coverage per calendar year? $_____or sessions ___
Co-Payment per Session: $_____ Other: _____

Are you available on any weekdays between 9AM - 3PM?
If so, which days?

☐ M ☐ T ☐ W ☐ Th ☐ F

Can you make early weekday morning sessions that begin at 7 am, 8am, or either?

○ Yes ○ No

Cancellation
Appointments cancelled within less than 24 hours of your scheduled appointment will be charged at the full rate of $130.00 to be paid at your next scheduled appointment.

I understand and agree to the above stated financial policy
Signed: _____ Date: _____

Authorization for release of Information and Assignments 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: _____

I agree to contact my insurance provider and obtain relevant insurance coverage including the required co-payment and deductible.
Signed: _____ Date: _____

For Office Use Only
Date of Initial Visit: _____
Dx Code: _____