

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: _____

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: _____

Last updated: 10/2/13