Intake Form

PATIENT'S NAME (FIRST, INITIAL, LAST) ____

PARENTS OF MINOR FIRST, INITIAL, LAST) ____

ADDRESS______________________________CITY_____________________STATE________ZIP________

CELL PHONE__________________ PATIENT'S BIRTHDAY______________ EMAIL_______________________

INSURANCE INFORMATION

INSURED'S NAME AND ADDRESS____

SS#_______________________ INSURANCE COMPANY__________________________________

ADDRESS____

GROUP NO. ____________________ INSURED'S EMPLOYER_________________ WORK NO. ______________

REFERRAL SOURCE____

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS: I/We consent that __________________________ may be treated as a client or clients by Jodi Taub, LCSW.

Signature(s) ____ **Date**______________________

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for the following: a) information shared with psychiatrists, nurse practitioners, and or any other medical professional managing mental health care) b) Information that you and your child or children report about physical or sexual abuse; then, by New York State Law, I am obligated to report this information to the Department of Children and Family Services, c) information shared with your insurance company to process your claims, d) information where you sign a release to have specific information shared, e) if you provide information that informs me that you are in danger of harming yourself or others. If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian understands they are to contact emergency services in the community for those services. Jodi Taub, LCSW. will follow up with those emergency services with standard therapy and support to the client or the client's family. Please note that any client whom I have not seen within a 6-month time period is no longer considered an active patient, and I am not responsible for their care.

Signature(s) ____ **Date**______________________

Financial/insurance issues: Please note that I am an Out of Network Provider. This means that I do not accept coverage for In Network Plans. If you do have Out of Network coverage, you may not receive a reimbursement from your insurance company.

PLEASE NOTE, THAT YOU ARE RESPONSIBLE FOR ALL OUT OF NETWORK INSURANCE BILLING AND COORDINATION. As an Out of Network provider, I will not have access to your health care plans and information. As a courtesy, I will send you an email receipt after your session with the necessary information required for session reimbursement. This is the approved information set by the insurance companies. It is your responsibility to obtain reimbursement from your insurance company.

YOUR FULL PAYMENT IS DUE AT THE TIME OF EACH SESSION.
If your insurance company denies payment or does not cover particular codes or coverage, you are still responsible for payment. If payment is not received at the time of the session, and unless otherwise agreed, I can deny further service. If your balance exceeds 14 days, Jodi Taub can deny further treatment. After 60 days any unpaid balance will

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be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. Lastly, we ask that every client authorize payment of medical benefits directly to Jodi Taub, LCSW.

I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments, please feel free to ask.

Jodi Taub, LCSW

I have read and agree to the above terms and expectations.

Signature(s)____________________________________Date:______________________________

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