LIFE DISCOVERY PSYCHOTHERAPY LLC
CONFIDENTIAL INTAKE FORM
786-719-4721

A PERSONAL INFORMATION

First Name		Last Name		M.I.		D.O.B.		Gender	
Street Address			Apt./Unit No.						
City/Town		State		Zip		E-mail			
Cell Phone		Home		Office			Ext.		
Circle Preferred Contact Method for Re-scheduling Purposes	Call Cell Phone		Call Home		Call Work		Email		
Primary Care Physician			Office Phone			Ext.			
Emergency Contact			Best Phone						
Relationship to Applicant									

B INSURANCE INFORMATION

Name of Primary Insurance Company							
Street Address					Suite No.		
City/Town		State		Zip		Phone	
Name of Insured (if different from patient)					D.O.B.		
Insurance ID #			Group #				

C BILLING INFORMATION .

Statement of Agreement	Initials
All insurance information and coverage is to be collected by the responsible party. For out of network coverage, an invoice will be provided for reimbursement according to the client's plan.	
I, the undersigned, acknowledge that I have received, read, and understood the Good Faith Estimate (GFE) provided to me. I am aware that the GFE outlines the expected costs of services and any anticipated fees associated with my treatment. I understand that the GFE is only an estimate, and actual costs may vary depending on changes in my treatment plan or additional services that may be recommended during my care.	
If insurance denies coverage, please note that the client is responsible for payment.	
Clinicians are available during office hours; Monday-Friday 9am-5pm. Calls made during the weekend or after office hours will be returned the next business day. If you have an emergency, please call 911 or visit your nearest emergency room. (***Note:*** *Life Discovery Psychotherapy does not have an on-call service, should an emergency arise, please contact 911 or visit your nearest emergency room.(All calls will be returned during office hours)*	

D AUTHORIZATIONS

AUTHORIZATION FOR RELEASE OF INFORMATION			
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.			
SIGNATURE		**DATE**	

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS FOR INSURANCE			
I authorize payment of medical benefits to my provider for services performed.			
SIGNATURE		**DATE**	

FINANCIAL POLICY		
Appointment cancelled with less than 24 hour notice will be charged to me at the full fee per hour. I am responsible for the entire balance of services performed regardless of whether there is insurance coverage. Secondary insurance will be billed as a courtesy. I understand and agree to the above stated financial policy.		
SIGNATURE		**DATE**

No Show & Cancellation Agreement

(Initials & Signature)

At Life Discovery, we are committed to providing you with quality care and consistent treatment. We also ask for your full participation and commitment for the best possible outcomes. As part of that commitment, we ask that you attend each appointment you schedule, and provide prompt notice of cancellation when you cannot attend. Please note that your insurance will not pay for the time you reserve when you make an appointment if you do not keep that appointment, therefore our cancellation policy is very important to our business and our ability to make a commitment to you.

- ***No-Show****: An instance in which, without communication, a client does not keep, or is unable to keep a previously scheduled and confirmed appointment. I understand that I am responsible to pay for the time I reserve with my therapist when I am unable to keep my appointment and I do not provide at least 24 hours' notice. I hereby authorize use of the credit card below to charge a "No-Show" fee. (full rate)* _____

- ***Late Cancellation:*** *An instance in which a client cancels an appointment less than 24 hours in advance of the appointment. (Monday cancellations must be received by 6 p.m. On Friday.) I understand that I am responsible to pay for the time I reserve with my therapist when I am unable to cancel my appointment within 24 hours of the appointment (or before 6 p.m. Friday, for all Monday cancellations). I hereby authorize use of the credit card below to charge a "No-Show" fee (full rate)* _____

Credit Card Information

Name of Credit Card:	
Credit Card Number:	
Expiration Date:	
CVV#:	
Billing Zipcode:	

Signature: _____

NOTICE OF PRIVACY PRACTICES

RECEIPT AND ACKNOWLEDGMENT OF NOTICE

PATIENT/CLIENT FULL NAME: _____

PATIENT/CLIENT DOB: _____ **SSN**: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Life Discovery Psychotherapy, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my clinician or coach.

_____ _____

Signature of Patient/Client Date

_____ _____

or Parent, Guardian or Personal Representative* Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

Legal Authority: _____

Patient/Client Refuses to Acknowledge Receipt:

_____ _____

Signature of Staff Member Date Date: