

INTAKE INFORMATION

Client Name: _____	Date of Birth: _____ Age: _____
Address: _____ _____	Social Security # _____
	Referred by: _____
Telephone: Home (____) _____	Emergency Contact: _____
Work (____) _____	Relationship to you: _____
Cell (____) _____	Address: _____
E-Mail Address: _____	_____
<input type="checkbox"/> Single <input type="checkbox"/> Married	Telephone: Home (____) _____
<input type="checkbox"/> Separated <input type="checkbox"/> Live W/ Partner	Work (____) _____
<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Physician's Name: _____
Primary Language _____	Address: _____
Employer: _____	Phone: _____
Occupation: _____	

AUTHORIZATION FOR RELEASE OF INFORMATION FOR BILLING PURPOSES:

I hereby authorize the release of any information necessary for third-party claim submission and/or payment for services, including use of a collection agency. In the case of default of payment, I agree to pay any collection costs and reasonable attorney fees incurred to effect collection of this account. I authorize payment of third-party benefits to Michael Rogell, Ph.D. for psychological services. I understand that I am responsible to pay Dr. Rogell for all sessions, including No Show Appointments. A No Show Appointment is a cancellation with less than 24 hours notice.

Signed _____ Date: _____

Fee Per 60 Minute Session: \$170.00

(Revised 6/2015)