

INTAKE INFORMATION

Client Name: _____

Address: _____

Telephone: Home (____) _____

Work (____) _____

Cell (____) _____

E-Mail Address: _____

Single Married

Separated Live W/ Partner

Divorced Widowed

Date of Birth: _____ Age: _____

Social Security # _____

Occupation: _____

Referred by: _____

Emergency Contact: _____

Relationship to you: _____

Address: _____

Telephone: Home (____) _____

Work (____) _____

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 Kaitlin Goodman, LLMSW. for psychological services. I understand that I am responsible to pay Kaitlin Goodman 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: _____