INTAKE INFORMATION

Client Name: _____

Address: _____

_____

Telephone: Home (____) _____

Work (____) _____

Cell (____) _____

E-Mail Address: _____

❑ Single ❑ Married

❑ Separated ❑ Live W/ Partner

❑ Divorced ❑ Widowed

Primary Language _____

Employer: _____

Occupation: _____

Date of Birth: _____ Age: _____

Social Security # _____

Referred by: _____

Emergency Contact: _____

Relationship to you: _____

Address: _____

_____

Telephone: Home (____) _____

Work (____) _____

Physician's Name: _____

Address: _____

Phone: _____

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)