Adult Intake Form

Name of patient:____

Date of birth: ____ Age: _____________________

Address: ____

City,State,Zip____

Preferred phone #:__________________________ May we leave a message? Yes No

Alternate phone #:__________________________ May we leave a message? Yes No

Employer and type of employment (if applicable):

____

Emergency contact (name, relationship to you, and phone number):

____

If applicable, please list current psychiatric medications with dosage:

____

____

If applicable, please list any other current medications with dosage:

____

____

Name of personal physician:

____

Name of psychiatrist:

____

____ ___________________________

Signature Date

For the following pages, please review and sign the section that pertains to you, whether you are filing your in-network BCBSNC insurance, will be filing out-of-network, or will be self-pay

In-Network Insurance Reimbursement – BCBSNC

*****complete this section if you will by using your BCBSNC insurance for services*****

Authorization to Bill Insurance

Patient:_____________________________ Guardian (if Minor):____________________________
Phone:______________________________ Address:______________________________________
Insurance Company:__________________ Plan Type: ____________________________________
Group/Policy #:_______________________ Member ID:___________________________________
Copay (if applicable):___________________Effective or Renewal Date:_______________________

Include a copy of the front and back of your insurance card

I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from Depth to Growth, PLLC. I therefore authorize Depth to Growth, PLLC to release my or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

I understand that my insurance company may have a contractual right to obtain any and all information about myself from Depth to Growth, PLLC for the purposes of benefit determination.

I understand and acknowledge that Depth to Growth, PLLC will submit my claims to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me either in person, or at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

____ _________________________

Signature Date

Out-of-Network Insurance

*****Sign this section only if you will be using out-of-network insurance. Please note that this therapist is only in-network with BCBSNC*****

I understand that my therapist is not a participating member of my insurance panel and my out-of-pocket expenses will be $160 for an intake session and $120 for recurring session.

I understand that my therapist will not file claims on my behalf but will provide me a statements to submit to my insurance company for reimbursement.

I understand that I will pay my therapist directly at the time of the session or within 30 days of receiving an invoice.

____ _________________________

Signature Date

Self-Pay

*******Sign this section only if you will not be using insurance*******

Unless otherwise agreed upon, I understand that my therapist's rate is $160 for an intake session and $120 for recurring sessions.

I understand that I will pay my therapist directly at the time of the session or within 30 days of receiving an invoice.

_______________________________________ _______________________
Signature Date