

CLIENT INTAKE FORM - INSURANCE

GABRIELLE LAWRENCE, Ph.D.

• 5040 E Shea Blvd, #268, Scottsdale, AZ 85254 • (480)607-5030 •

PLEASE PRINT ALL INFORMATION

Today's Date: / /

CLIENT's Full Name:

Additional Information if Minor

Mailing Address:

School:

City/State/Zip:

School Phone:

Home# ())

Teacher:

WK# ())

Mother's Name:

Cell# ())

Father's Name:

SSN#: - -

Referred by:

Date of Birth: / /

Relationship to Insured:

Legal Involved? Yes No

Married ___ Single ___ Divorced ___

Write lawyer's Name, Address and Phone

What brings you into my office:

INSURED's Full Name:

PLEASE PRINT ALL INFORMATION

Mailing Address:

Telephone, Home: ())

Business ())

Cell())

Date of Birth: / /

Social Security No.:

Employer (insured):

MEDICAL

PLEASE PRINT ALL INFORMATION

Previous Therapy: Yes No

Therapist's Name:

Physician's Name:

Last Date of Service: / /

Date of Last Physical:

Therapist's Phone: ())

Physician's Phone: ())

MEDICATIONS:

INSURANCE COMPANY NAME/ADDRESS:

Member ID #:

Group/Policy #:

Phone: ())

Is this an EAP? **Yes** **No**

Deductible: Has been met? **Yes** **No**

Co-Pay Amount:

Sessions Allowed:

Policy Effective Date:

Is Authorization Required? Yes No

Authorization # (if required):

We will bill for all insurance-covered visits unless requested by you the client.

Authorization effective dates:

I authorize the release of any medical or other information deemed necessary by Dr. Lawrence to facilitate the therapeutic process. I, also, give my permission to Dr. Gabrielle Lawrence to confer with the above for the purpose of my treatment.

Client or Legal Guardian, if Minor

Date

I authorize payment of medical benefits to the named provider for medical services rendered.

Insured

Date

For Office Use Only: I _____ II _____ III _____ IV _____ V _____

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PAYMENT POLICY

1. A Therapeutic hour is fifty (50) minutes of counseling time.
2. Initial consultation: \$155.00 per hour. Additional visits \$140.00 per hour.
3. Copays are accepted if you have AZ Foundation, Aetna, Beech Street, or Humana life Sync. and BC/BS . The Insurance Addendum must be filled out in its entirety and given to Dr. Lawrence before this will apply. **Prior to you session, please call your insurance to determine your co-pay and deductible. Co-payments are expected at the time of the session. If your insurance reimburses only a portion of the session fee, you will be responsible for the balance (i.e., they only pay 80% of \$140.00; the only exception would be if Dr. Lawrence is contracted with the above managed care companies and has agreed to an in-network discounted rate). If for some reason your insurance denies payment of any billed service you will be responsible for the full fee.**
4. There is a fee for all telephone consults and written or email correspondence, please see fee schedule for rates @ www.health4relationships.com. Legal fee schedule is also available upon request.
5. Cancellations need to be made twenty-four (24) hours in advance of appointment time on a business day schedule (i.e. Monday appointments must be cancelled on the previous Friday to avoid cancellation fee). If cancellation is less than twenty-four (24) hours, a session fee of \$140.00 will be assessed. The office number is **480-607-5030**. Messages are not retrieved on Saturday or Sunday.
6. "No Shows" and Late Cancellations will be assessed at the full session price of \$155.00 or \$140.00 and need to be paid before client can reschedule another session.
7. All fees are expected at the time of the session. Client must pay the therapist before the hour begins. Cash or checks will be accepted. Checks can be made payable to: Gabrielle Lawrence, PhD. Mastercard and Visa also accepted.
8. If it is necessary to send you to collections for an unpaid balance you will be responsible for all commission fees that will be added to your bill at that time.
9. Anyone unable to meet the above financial obligations should speak directly with Dr. Lawrence about this matter in the consultation.

I have read and understand the above policies and accept full responsibility for any outstanding balances on my account.

Client or Legal Guardian, if Minor

Date

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this fax/email/document, including any attachments, may contain confidential and privileged information and is for the sole use of the intended recipient(s). Any unauthorized review, use, disclosure or distribution is prohibited.