Kristin Koberstein, MA, LMFT

(Patient Intake Information)

DX: ________________________________

(Office Use only)

DATE: ____________________

PATIENT NAME: ____
(Last) (First) (Middle)

PATIENT ADDRESS:____

____

EMAIL ADDRESS:____

DATE OF BIRTH: ______________________ SEX: F M (Please circle)

Circle whether message can be left

PATIENT HOME TELEPHONE NUMBER: (Incl. Area Code) ________________________ YES NO

PATIENT CELL PHONE NUMBER: (Inc. Area Code): ______________________________ YES NO

PATIENT WORK PHONE NUMBER: (Inc. Area Code) _____________________________ YES NO

PLACE OF EMPLOYMENT: ____

Name of Spouse: ____ Date of Birth of Spouse: ____________________

If different than above, please complete this block

RESPONSIBLE PARTY NAME: ____
(Last) (First) (Middle)

ADDRESS: ____

____

DATE OF BIRTH: ____________________ SEX: F M (Please Circle)

HOME TELEPHONE NUMBER: (Incl. Area Code) ___________________________________

PLACE OF EMPLOYMENT: _____________________________Work Phone Number: _____________________

INSURANCE INFORMATION:

Insurance Name: ____

Insurance Company Phone Number: ____

Policy Number: ____

Group Number: ____

Policyholder Name: _________________________ Policyholder Date of Birth: _______________

Patient's Relationship to Policyholder: ____

OTHER CONTACT INFORMATION:

Primary Care Physician __________________________________ Phone Number _______________

Emergency Contact Person: __________________________ Phone Number ______________

NOTE: CONSENT INFORMATION ON BACK OF FORM MUST BE REVIEWED AND SIGNED.

CONSENT AGREEMENTS:

Patient or Authorized Person's Signature:

I have been given an opportunity to look over a copy of the Notice of Privacy Practices for Kristin Koberstein, MA, LMFT. A copy for your records can be provided if requested.

I consent to assessment and treatment by Kristin Koberstein, MA, LMFT, who may examine my medical records, and discuss my case with the attending (or primary care) physician who may be involved in my care before or after I am examined or treated here.

I authorize release of information to process insurance claims. I authorize the release of any medical or other information necessary to process this claim. Photocopies or reviews of relevant documents may be sent to the insurance company in order to clarify payment of benefits.

I authorize payment to Kristin Koberstein, MA, LMFT, for services provided.
I realize that there can be monetary limits for mental health benefits imposed by my insurance company that can involve a maximum dollar amount per year or lifetime, pre-certification and a number of visits allowed in a time period. I agree to accept full responsibility for fees and payment once these limits have been reached.

If I am using out-of-network benefits I agree to pay the full fees charged at the time of service and am aware it is my responsibility to obtain reimbursement from my insurance company by submitting a claim. The amount the insurance company covers may not be the entire charge. The current fees are described in the Statement of Practice that will be discussed in the first session. I have received a copy of these fees.

I hereby assign and set over to Kristin Koberstein, MA, LMFT, any benefits for the cost of treatment that may be entitled. I authorize the third party Payor (i.e. Insurance Company, if applicable) to make payments directly to Kristin Koberstein.

I am also aware that the insurance company may not cover certain fees that may be needed for consulting with other medical or legal professionals in regards to my care; for example, telephone consulting fees and fees for written reports. I accept full responsibility for fees and payment of fees not covered by my insurance company.

I understand that I may be charged a fee for appointments that I cancel without sufficient notice or miss, and that my insurance will not cover these charges. The fee is $50.00 for missed sessions and $30.00 for late cancellations. In these cases no insurance benefits will be available. (There is a 24-hour, seven day a week phone number available.)

If I am involved in domestic litigation or become a party to a divorce or custody action, I agree that I will not call Kristin Koberstein to court to testify. Courts appoint professionals who have had no prior contact with a family to conduct custody evaluations and to make recommendations to the court. As a clinician, Kristin Koberstein's role is to provide treatment, and not to make recommendations to courts in domestic matters. I agree to the policy to not have my counselor testify in such cases, because experience has shown that the professional relationship is often harmed when counselors testify in domestic cases. By signing this form I agree not to call Kristin Koberstein as a witness in domestic litigation.

I understand that I am financially responsible to Kristin Koberstein, MA, LMFT for charges not covered by this assignment and co-payments determined by insurance carriers or payments made directly to me.

SIGNATURE: ________________________________ DATE: ____________________

If guarantor, relationship to patient: _________________________