

**Integrative Psychotherapy**

**Initial Appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Negotiated session rate:\_\_\_\_\_\_\_\_\_/50m**

**Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Id Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Subscribers name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Deductible:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Co-pay per visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that my insurance will be billed for each session by clinician’s office, however if my insurance is not valid or is rejected then I am obligated to pay for services that were rendered at the contracted insurance rate and will not be charged full fee rate.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date\_\_\_\_\_\_\_\_\_\_\_\_\_**