INTAKE FORM

Date: _____

Patient Full Name: _____ Date of Birth: _____ Age: _____ Sex: M F

Address: _____ City/State/Zip: _____

SSN: _____ Employer/Phone: _____

Cell Phone: _____ Email Address: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Primary Physician: _____ City/State: _____ Phone #: _____

If patient is a MINOR, parent/guardian's name and signature here: _____

How did you hear about us? ❑ Friend/Family ❑ Internet ❑ Facebook ❑ Advertisement ❑ Other: _____

IMPORTANT RULES & POLICIES

1. Late Policy: If I am more than 10-minutes late to my appointment, I may be rescheduled or asked to wait for next available open time slot.
2. 24-Hour advance notice is required for changes to my appointment otherwise a $50 fee may apply.
3. Not showing for an appointment without notice (or less than 24-hours in advance) will result in a $50 fee added to my account.
4. Co-pays and/or deductibles are due prior to treatment starts.
5. Cell phones must be shut OFF or silent.
6. Children requiring supervision are NOT allowed to attend sessions with you without prior authorization.
7. If you are experiencing any financial hardship, please notify us immediately so we can create a payment program that is feasible.
8. If for any reason you are NOT satisfied with the care received, please call our administrator at (712)256-1800.

Signature:_____ Printed Name:_____ Date:_____