Jennifer Cory, Ph.D.
PSY20743

Client Intake Information

General

Name:_____ Birth Date:_____ Today's Date:_____

Cell: _____ Alternate Phone: _____ Email: _____

Address: _____

Driver's License # and State: _____

Age: ____ Occupation:_____ Education Level:_____

Marital Status: _____ Name(s) & Ages of Children_____

Referred By: _____ Emergency Contact: _____ Cell:_____

FINANCIAL

I, _____ agree to pay $220 + $10 credit card processing fee per 50 min session or ____ Co-pay based on my health insurance plan. If you would like to pay via Zelle to avoid credit card processing fees the transaction must be done at the beginning of session. A $500/ hr will be charged for any additional written reports for court purposes, insurance needs, phone consults, disability or other requested reports. There will be a $1000/hour for any court appearances needed including time traveling to and from any legal proceedings, time consulting with attorney's, all needed prep time for any court and deposition appearances. **PLEASE INTIAL____ DATE:** _____

It is customary for the fee to be paid at the time of service rendered. Any other payment plan needs to be arranged in advance. A statement from my billing department will be available each month for services rendered during the previous month at request. Please contact Linda at 619-889-4513

Please provide the billing department with your insurance information if we will be billing your insurance for you. If not it is the client's responsibility to complete the insurance form and mail it to his/her insurance company. As a service, we will bill your insurance for you If you have an out of network PPO plan. Any payments will be sent directly to you after a 30 days billing cycle by your insurance provider and the full fee for my services will be due at the time of service. **INTIAL ___ DATE:** ___

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As stated above, as an additional service to my clients I provide a billing person who will contact your insurance carrier and review your insurance benefits under my care. However, insurance carrier's have been known to misquote benefits. It is ultimately your responsibility to know your benefit coverage and deductible status. Insurance providers have been known to not pay or mistakenly pay for services rendered. In which it is the clients responsibility for any outstanding balances their insurance carrier will not pay.
I, _____ understand that all services rendered are my responsibility to pay in full.

Fees are subject to future change with 30 day notice. I further understand that I will be charged the full fee of $220 for appointments not cancelled 24 hours in advance of the schedule appointment time. PLEASE INTIAL:_____
DATE:_____

I, _____ understand that I am financially responsible for the charges incurred during the course of my therapy or therapy of my immediate family. I also understand that I may be assessed at late charge on any balance due over 60 days and if the account needs to go to a collection agency my confidentiality will be breached to the extent necessary to process the case. If legal action is necessary on this account. **PLEASE INTIAL _____ DATE: _____**

CREDIT CARD INFORMATION

It is customary to keep a credit card on file to pay any deductible, missed appointment fees or copay you may have. Please fill out your Credit Card number below:

Credit Card type: (Visa/MC/Amex/HSA): _____
Credit Card Number _____ _____ _____ _____ CVV# (on Back)_____ exp date:_____Name on Card: _____
Billing Address:_____
Zip Code: _____
I Authorize Jennifer Cory, Ph.D. to charge my Credit card for service:
signature:_____

My Billing Person, Linda Griebel, will submit your services to your insurance company upon request. Any outstanding balances or unpaid insurance claims will be charged to your card after 60 days.

I agree to pay such sum as the court may fix as attorney's fee in addition to court costs. A photostat of this agreement shall be as valid as the original. **INTIAL___**

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SOCIAL MEDIA

To protect your privacy I do not accept requested to connect on Facebook, Instagram, Linkedin, etc. **INTIAL_____ DATE: _____**

CONFIDENTIALITY

Services are confidential except when limited by California law. If a therapist suspects that any past or present physical or sexual abuse, neglect or mental suffering was perpetrated upon a minor, dependent adult, or elder adult, or where there may be minors still at risk (minor include current pregnant women carrying an unborn child/ children), he/she must immediately consult with the appropriate reporting agency and may need to make a verbal and written report to them. Cases that raise the question of a threat to one's own life, another's life or threat to property may also be reported to the appropriate agency. Signing below indicates that you understand these limitations on confidentiality. A copy of this form will be provided upon request. All other communications are kept strictly confidential and may not be revealed to anyone without prior written or verbal permission by the client. When applicable it is understood that minors confidentiality will be held with the exception of the above mandates.
PLEASE INTIAL_____ DATE:_____

AREAS OF CONCERN

What issues/concerns caused you to seek services at this time?
_____
_____
What are your goals? _____
_____
Do you have any concerns/fears with regard to therapy? _____
_____
Are you currently under the care of a psychiatrist? _____ Name_____

BY SIGNING BELOW I AGREE TO ALL THE TERMS OF THIS DOCUMENT: (a copy will be provided upon request)

Signature : _____ Printed Name: _____

Date: _____