Peter Gambino, PhD
269 Hempstead Ave
Malverne, NY 11565
516-256-1740

First Date of Treatment ______
DSM Code# _____________
Returning Patient ___________

INTAKE FORM- Please bring completed form on your first visit.

A. Personal Information

Patient Name____ Date of Birth ________

Address ____ M F

City/State/Zip ____ Marital Status ________

Home Phone (   )____________________Work #(   )_______________Cell# (   )___________

Social Security # _____________________________ Email Address_____________________________

Primary Care Physician ____________________________________Phone # (   )________________

Address/City/State/Zip ____

B. **Responsible Party** (Fill in if under 18 or someone other than patient is responsible for payment)

Name____

Address ____

City/State/Zip ____

Home Phone (   )____________________Work #(   )_______________

Relationship to Patient ____

C. Insurance Information
Primary Insurance Company____

Address ____

City/State/Zip ____ Phone # _____________

Insurance ID# _________________________________ Group # ________________________________

Name of Insured (if different from patient) ____

D. **Insurance Coverage Information** (if known)

Annual Deductable ____
Insurance coverage per session 100% 80% 50% other ____

How much coverage per Calander Year? $____________or number of sessions per year________________

Co-Payment per session $_________________________ Other __________________________________

E. Authorization Information

Authorization # ___________________________________ Number of Sessions Authorized ______________

Date Authorization Starts ____________________________Date Authorization Ends ________________________

For Authorization Call (   ) ______________________________ext ______ Fax # (   )___________________

F. Self-Pay/No Insurance

I agree to pay $__________per session at the time of service.

Signed ____ Date _________________________

G. Billing Information
Send Claims to Primary/Secondary Insurance _________
Send Claims to insurance but collect from Patient ____ Responsible Party ____
Send Bills for co-payments/deductible to Patient ____ Responsible Party _____
Send HCFA form to Patient _____ Responsible Party ______

Special Instructions____

H. Financial Policy

***Appointments cancelled with <u>less than 24 hour notice</u> will be charged at the full session fee*.**

I am responsible for the entire balance of services performed regardless of whether there is insurance coverage.

Secondary Insurance is billed as a courtesy,

I understand and agree to the above financial policy.

Signed ____ Date ___________________________________

I. **Authorization for release of Information & Assignment of Benefits of Insurance**

I authorize the use or disclosure of my peronal health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that the organization is authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Signed ____Date_____________________________________

I authorize payment of medical benefits to my provider for services performed.

Signed ____Date______________________________________

If there are any changes in your circumstances please notify this office immediately.