Steve Shealy, Ph.D., Licensed Psychologist
CLIENT INTAKE FORM ***(PLEASE PRINT)***

Name _____ Date of Birth _____/_____/_____
First Middle Last

Social Security number _____ - _____ - _____ Gender M ___ F ___

Address _____
Street City State Zip

Phone: home _____ work _____ cell/pager _____

Email Address _____ **Referred by** _____

Employer _____ Employee ID #_____

Spouse or Significant Other _____ Phone # _____

Emergency Contact _____ Phone # _____

PAYMENT METHOD: Credit Card: Visa___ M/C___ **Cash**____ **Check**____

Card # _____/_____/_____/_____ Exp ____/____ Name on Card _____

Alternate Credit Card:

Card # _____/_____/_____/_____ Exp ____/____ Name on Card _____

CLIENT AND INSURED INFORMATION (necessary to receive your insurance benefits.)

I will get the necessary information from our insurance card (I'll need to photocopy it.)

Primary Insurance Company _____

Secondary Insurance Company _____

AUTHORIZATION I hereby authorize Steve Shealy, Ph.D., to release the information necessary to process my insurance claims (e.g. diagnosis, dates of service). I request payment of benefits to be made to Dr. Shealy for services rendered if my insurance company allows this (e.g. BCBS does not, Medicare does).

I understand that I am responsible for any balance not paid by my insurance company.

I understand that I will be charged for appointments that are missed (i.e. late cancellations and no-shows) without at least 24 hours prior notice.

I have received a copy of "Notice of Privacy Practices".

Your Signature _____ Today's Date _____/_____/_____