HRA PSYCHOLOGICAL SERVICES

New Client Intake

HRA Staff Only
HRA Staff Initials: _____ Intake Date: _____ Provider: _____
Appt Date/Time: _____ Testing Date/Time: _____

Name of person requesting the appointment: _____

Legal Client Name: _____ Preferred Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Age: _____ DOB: _____ Gender: □Male □Female □Other: _____

Phone: _____ Email: _____

How did you hear about clinician / HRA?
□HRA Website □Insurance Provider □Psychology Today □Personal Referral: _____

In general terms, the focus of treatment:

_____

_____

Which clinician are you interested in seeing (if any)?: _____

Insurance Information
Would you like us to bill your insurance? □Yes □No (*If yes,please fill out info below.*)
Carrier: _____ Policy Holder: _____
DOB: _____ ID#:_____ Group#: _____
Have you called your insurance company for authorization? □Yes □No □Not Required

For Minor Clients Only
Parent/Guardian Name: _____ Parent/Guardian Name: _____
Parent's Status: □Married □Divorced □Separated □Single □Widowed □Other: _____
Are both parents aware that treatment has been requested? □Yes □No □Not Sure

Consent for Payment

I hereby authorize payment of medical benefits through my insurance policy to HRA Psychological Services. I have listed all health plans from which I may receive benefits. I hereby accept responsibility for payment for any services provided to me that are not covered by my insurance.

I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for any missed appointment/late cancellation fees, NSF check fees, and a $10.00 charge per month on all overdue balances (past 60 days).

I hereby authorize HRA Psychological Services to use and/or disclose my health information which specifically identifies me or that can reasonably be used to identify me to carry out my treatment, payment, and health care operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, HRA Psychological Services can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions taken by HRA Psychological Services prior to receipt of my revocation.

I further give authorization to run my credit card if I choose to call and pay for services over the phone.

You can review HRA's full financial policies at: hrapsychservices.com/doc/hra-financial-policies.pdf

_____ _____

Legal Signature of Patient or Patient's Representative Date

_____

Name of Patient (Print)

_____

Relationship of Representative to Patient

Signature Form for Acknowledging Receipt of Notice of Privacy Rights

Please read and review our health privacy policies here:
hrapsychservices.com/doc/hra-hipaa-rights.pdf

My signature below indicates that I have received the **Notice of HRA Psychological Services Policies and Practices to Protect the Privacy of Patient Health Information** as required by law.

_____ _____
Legal Signature of Patient or Patient's Representative Date

_____
Relationship of Representative to Patient

_____ _____
Witness Date