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Phoenix, AZ 85020

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Clinical Psychologist

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Intake Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone (W) _____ (H) _____ (email) _____

Social Security# _____ Employer/Occupation _____

Age _____ DOB ____/____/____ Education _____ Male ____ Female ____

Height ____ ft. ____ in. Weight _____ lbs. Marital Status _____

Spouse's name _____ Age _____ Occupation _____

Children (name/age) _____

Where you grew up _____

Siblings: Names and Ages: _____

Referral source (name) _____

Medical or Psychiatric Conditions _____

Name/dosage of the medication(s) _____

Medication(s) prescribed by _____

Have you received psychological counseling Yes ____ No ____ or Hypnosis Yes ____ No ____

If yes, name of provider _____ Dates of service _____

Reason for termination of treatment? _____

Insurance Information: (complete only if you will be using insurance. Include secondary insurance on the back)

Insurance Co.: _____ Tel: _____

Address for Claims: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's Social Security#: _____ Policy ID# _____ Group# _____

Insured's Employer: _____ Work Tel: _____

Confidentiality: What is discussed in therapy is strictly confidential until you give written consent to its release, with two exceptions: Dr. Zeig is compelled by law to inform appropriate other person(s), including legal authorities, if he believes that a patient is in danger of hurting him/herself or someone else, and/or if there is reasonable suspicion that a child has been abused.

Please Note: Unless financial arrangements have been made in advance, payment is due at the time services are rendered. We are happy to submit claims to your insurance carrier. You may however, be rebilled by Dr. Zeig, Ph.D. for any co-insurance, deductible or non-covered services. You may be billed for all appointments cancelled without 24-hour advance notice.

Insurance Authorization, Privacy Notice and Polices: I authorize my insurance to make payments directly to Dr. Dr. Zeig for services I receive. I have read the information regarding financial arrangements in the paragraph above. I understand that I am financially responsible for all charges incurred by me during the course of treatment, regardless of any insurance coverage I may have. I acknowledge that I have received a copy of the office's Notice of Privacy Practices and Patient Confidentiality Form. I have read and agree to the Office Policies and Procedures.

Emergencies: Dr. Zeig travels frequently to teach and may not be available to assist with emergencies in which case you should contact the local emergency room.

Client or legally authorized signature

Date