Rebecca Kincaid
2709-B Pinedale RD.
Greensboro, NC. 27410
Phone: (336) 288-9900 Cell: (336) 707-6311

CLIENT INTAKE FORM

Today's Date _____/_____/_____ **Therapist: Rebecca J. Kincaid**

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (May we thank them? Yes or No) ❑ Dr. _____ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Email Address:	Alternative Email Address:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? _____

Please Select Your Primary Insurance Provider
❑ Blue Cross/Blue Shield
❑ Health Choice
❑ Medicaid

What is the authorization number? ❑ Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

LIST ALL ALLERGIES: _____
LIST MEDICATIONS: _____

Rebecca J. Kincaid

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

Agreement to Pay

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Rebecca Kincaid, M.S., LPA will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions. I agree to pay $150.00 per 50 minute session. I also understand that I will be charged $50.00 per hour for sessions cancelled less than 24 hours in advance and for appointments not kept. Therapist time outside of sessions will also be charged or prorated at this same rate for scoring, interpretation and report writing, court appearances, if necessary, and for phone calls in excess of ten minutes.

X _____

CLIENT/PARENT/GUARDIAN SIGNATURE DATE

Consent for Treatment/Service

I hereby consent to treatment and/or services by Rebecca Kincaid, Licensed Psychological Associate. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop. If the client is a child, I certify that I am also the legal guardian for the child.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Authorization to Release Information to Your Insurance Provider:

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Authorization to Collect Insurance:

I authorize the payment of medical benefits to the provider of services, Rebecca Kincaid.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

North Carolina Notice of Privacy Practices Information HIPPA and Client Rights :

I have received, read, and given the opportunity to understand the Notice of Privacy Practices information provided to me by Rebecca Kincaid, M.S., LPA in compliance with the Health Insurance and Portability and Accountability Act (HIPPA). I also acknowledge receipt and opportunity to read and understand client rights.

X _____

CLIENT/GUARDIAN SIGNATURE DATE THERPIST SIGNATURE DATE

Court Appearances:

I also agree that under no circumstances will I call or have anyone that is representing me call Rebecca J. Kincaid to testify as a witness for any court proceedings or for a deposition unless she feels that there is an immediate danger to the client.

X_____Date:_____

Client/Guardian Signature