

KAREN ROSE, MFT

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510-486-1188

NEW CLIENT INFORMATION AND SIGNATURE INTAKE FORM

I. PERSONAL INFORMATION

Your Full Name: _____ Email: _____

Home Address: _____

City, State, Zip: _____

Home Phone #: _____ Other Phone #: _____

Date of Birth _____ Soc. Sec. # _____

Your Current Employer: _____ Work Phone # _____

Emergency Contact Person: _____ Relationship: _____

Emergency Contact's Phone #: _____

Primary Care Physician: _____ Office Phone #: _____

II. INSURANCE – ATTACH A COPY OF YOUR INSURANCE CARD

INSURANCE COMPANY:

INSURANCE COMPANY MENTAL HEALTH PHONE#:

SUBSCRIBER ID:

AUTHORIZATION#:

III. CONSENT TO RELEASE OF INFORMATION

I hereby authorize Karen Rose to release any information necessary to facilitate the processing of insurance claims submitted on my behalf for services she renders to me.

IV. AUTHORIZATION OF PAYMENTS

I hereby authorize payment of insurance benefits to Karen Rose for services she renders to me. I understand that this authorization will remain in effect unless I terminate the authorization in writing.

V. PRIVACY POLICY AND OFFICE POLICIES

I hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices and Office Policies. I understand and agree to comply with them.

VI. CANCELLATIONS, CO-PAYMENTS, DEDUCTIBLES

I understand and agree that a 48 hour notice is required for cancellation of a session. I will pay for any missed sessions or sessions canceled late as per my insurance company's regulations. Insurance will not be billed for those sessions. I am responsible for all co-payments, deductibles and payments for sessions not covered by my insurance company. *

VII. FOR MEDI-CAL CLIENTS ONLY

I have been offered an Advance Directive, a Guide to Medi-Cal Mental Health Services, a CBHS Provider Listing and Client's Rights information sheet.

Signature: _____ Date: _____

*If you need to reach Karen to change or cancel an appointment with less than 48 hours notice, please call 510-486-1188. Only use email for non-urgent communication. Thank you.