Glenise Parrott, LCSW

1122 Sam Newell Rd
Suite 106
Matthews NC 28105

Phone: (704) 243-8776 **Email: gparrott@charlotte-therapist.com**

CLIENT INTAKE FORM

(Please Print)

Today's Date _____/_____/_____

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	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. __________ ❑ Insurance Plan ❑ Website

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other __________

Email Address:	Alternative Email Address:

INSURANCE INFORMATION

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

❑ Carolina Behavioral Health Systems ❑ Blue Cross/Blue Shield

❑ Tricare ❑ Medcost

❑ Other ______________________________________

What is the authorization number? ❑ Self Pay

Insured's First Name	Insured's Last Name	Birth Date / /	Group #	Policy #	Co-Payment $

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.

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Financial Policy

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at each appointment. I understand the charge to be $150 for the initial appointment and $130 each subsequent appointment <u>if not covered by insurance.</u> I understand that missed appointments or cancelled appointments where 24 hours notice was not provided will be charged the full fee. I understand that this charge is not covered by insurance and is my responsibility. I understand that I will be charged $50 should my records have to be provided to another party at my request. I understand I will be charged $50 for any letter or report that I request or require to be completed on my behalf. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.
Glenise Parrott, LCSW will honor contractual agreements made with those managed health care companies that stipulate specific reimbursement restrictions.

X ____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by Glenise Parrott, LCSW. 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 end treatment.

X ____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize Glenise Parrott, LCSW to file my insurance claim on my behalf for services rendered, and authorize the release of necessary medical information for insurance reimbursement purposes.

X ____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X ____

CLIENT/GUARDIAN SIGNATURE DATE