Jennifer White-Baughan Ph.D.

Initial Intake

Date _____

Client Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone: Home_____ Cell_____Work_____

Client SS #_____ Insured SS#_____

Age_____ D.O.B _____Gender of client_____

Referral source_____

Permission for Treatment of **Self**

I _____ give my consent for assessment, diagnosis and treatment conducted by Dr. White-Baughan Ph.D.

Permission for Treatment of **Minor ONLY**

I _____, as the biologic parent or legal guardian of the minor_____ give my permission and consent for psychological assessment, diagnosis, and treatment to be conducted by Dr. White-Baughan Ph.D.

Legal Guardian _____

Biologic Mother_____

Address_____

Biologic Father_____

Address_____

READ CAREFULLY

I agree for assignment of benefits to be paid directly to Dr. White-Baughan. She may file using electronic billing and or a HCFA 1500 as appropriate to my insurance carrier protocol. I agree to pay the co-pay at the time of service. If cash or out of network arrangements are made, I agree to the negotiated fee as discussed with Dr. White-Baughan.

We use Sourcenet Medical Billing Associates, LLC as a preferred vendor for practice management and billing services. Sourcenet will only have access to PHI as it relates to the adjudication of health insurance claims on your behalf. You are responsible for calling your insurer and getting clarity about: your need for authorizations, clarification of all benefits, an understanding of deductibles unmet and amount and keeping track of the number of sessions you have used. If treatment plans are needed from your insurer you must provide them to Dr. White-Baughan in a timely manner before you run out of sessions. CALL YOUR INSURER WITH QUESTIONS.

Client or client's representitive signature of understanding:_____

Jennifer White-Baughan Ph.D.

Insurance Information

Name of Insured _____

Employer_of Insured_____D.O.B of Insured_____

Insurance_Company_____

Policy #_____Group #_____

copy of insurance card here

Copay to be paid at time of service

I agree to pay copay at time of service_____

Cancellations without 24hr. notice will incur the full fee charge of $150/hr or the maximum allowable fee will be added to your balance to be paid at the next scheduled session.