24 South 600 East Suite 6
Salt Lake City, UT 84102

Matt Larson, LCSW Psychotherapy & Associates
ph (801) 599-6396 fx (801) 521-0688

1226 W South Jordan Parkway #A
South Jordan, UT 84095

NEW PATIENT INTAKE FORM

THERAPIST: **TODAY'S DATE:**

PATIENT INFORMATION

Last Name	First Name	Middle	
Address	**City**	**State**	**Zip**

Social Security Number	Date of Birth	Sex	Email Address

Mobile Phone #	Home Phone #	Work Phone #

Occupation/Employer & Address

GUARANTOR/PAYOR & OR GUARDIAN

Last Name	First Name	Middle	
Address	**City**	**State**	**Zip**

Social Security Number	Date of Birth	Sex	Email Address

Mobile Phone #	Home Phone #	Work Phone #

Occupation/Employer & Address

INSURANCE INFORMATION

Company Name	Ins. Phone #	Member / ID #	Authorization #
EAP Ins. Name	EAP phone #	Member / ID #	Authorization #

EMERGENCY CONTACT

Name	Address	Phone#

INITIAL

CONTRACT TO PAY FOR SERVICES

Terms Net 30 days from the date of invoice unless otherwise indicated above. A FINANCE CHARGE of 1 1/2% per month (18% per annum) of the unpaid balance will be added monthly. Should collection become necessary by legal suit or other means, the customer agrees to pay all costs of collection including attorney fees, court costs, filing fees, including charges and collection agency fee which would be $100.00 or 1/2 of the balance assigned, whichever is more, with or without suit. The patient is also responsible for all amounts not covered by insurance.

X_____

RELEASE OF INFORMATION

I/we authorize the above listed therapist to disclose case records (diagnosis, case notes, or other requested material) to the insurance company or third party payer I have named above for the purpose of receiving request of authorizations and or billing for services rendered.

I also hereby agree to enter treatment at 24 S. 600 E.Ste 6 or 1226 W. South Jordan Parkway Bldg # A and I have read and understood client rights and purposes of treatment. Services unpaid are rights for denial of treatment.

X_____

24-Hour Notice

If you cannot keep an appointment that you have scheduled, please give notice of at least 24 hours in advance to avoid a $100.00 fee.

X_____

PHONE/TEXT AND MISCELLANEOUS FEES

Phone therapy sessions, texting, preparation of special forms, insurance reports, court time, consults with other professionals etc., are billed and paid out of pocket by the patient at a rate of 25$ per 15 minutes.

X_____

HIPAA POLICIES AND PRACTICES

I have been provided the opportunity to read and receive a copy of the listed office HIPAA Policies and Practices document regarding the protection of my health information. I understand that it is my responsibility to read this document in it's entirety. I have been given the opportunity to inquire and clarify any information of this document that is unclear to me.

X_____

Patient Signature	Date	Parent/Guardian signature if patient is a minor	Date

Therapist Signature	Date