All in 1 SPOT with TheraTalk
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Intake Form

Patient's Name:_____ Person Filling out this form:_____
Date of Birth: _____Today's Date: _____
Age: _____ Female r Male r Email: _____
Home Address: _____Home Phone:_____
If patient is a child:
Mother's Name:_____ Father's Name:_____
Mother's DOB: _____ Father's DOB: _____
Mother's Cell Phone#:_____ Father's Cell Phone #: _____
Mother's Work #:_____ Father's Work #_____
Mother's Social Security #:_____ Father's Social Security #:_____
Child/Patient's Social Security#:_____
Child lives with: Father r Mother r Both r Other r_____

Health Insurance Information:
If services provided through insurance who is the primary cardholder:

_____
Primary Cardholder's Social Security #_____
Primary Cardholder's DOB:_____Primary Insurance: _____
Policy Number: _____Group Number: _____
Policy Holder's Name of Employer:_____
Insurance's Phone Number: _____Insurance's Billing Address: _____

Referred by:_____
Allergies:_____
Emergency Names and Numbers:_____
_____
Child's Physician: _____ Physician Phone #:_____

(If services provided through department of education, please complete the following:
Patient's School:_____
School District:_____
Administrator's Name:_____
IEP Mandate (# of sessions x duration):_____
Approval Date:_____ Start Date:_____)

Office Policies:
Payment Policy: 100% of all office visits, other treatments, and supplements fees are due at the time of services. We accept cash and/or checks as payment. All sales are final. We cannot provide refunds or exchanges. We charge $25.00 for any returned check.
Cancellation Policy: Last minute cancellations of scheduled appointments are challenging to fill, wasteful of an opportunity for another patient, and costly for the clinic. We therefore require changes or cancellations to be made at least 24 hours prior to your scheduled appointment. Otherwise, you will be charged $35.00 for the 2nd missed visit, and for any subsequent missed visit.
I understand that I am financially responsible for all charges regardless of insurance coverage and or treatment outcome. I further understand that 100% of fees are due at the time service is rendered, and that all sales are final. I understand that I will be charged for any appointment missed or cancellation less than 24 hours in advance as explained above. I hereby agree to pay any and all charges.

Patient/Parent/Guardian Signature:_____ Date:_____
(*Saved as intake sheet for new patient)