Amy S. McNulty, Ph.D., MSW
3541 Randolph Road Suite 102-W
Charlotte, NC 28211

INTAKE FORM

Date:___________________

Client Name: ____
(Last) (First) (Middle)

If a minor, name of parents:____

Home Address:____
(Street Name) (City) (State) (Zip)

Home Telephone #: _______________________________ Work Telephone #:_______________

Cell Phone #: ______________________________ Other Telephone #'s:_____________________

Occupation:_________________________________ Employer:_____________________________

Age:__________ Date of Birth:_________________________ Marital Status:_________________

Social Security Number:_____________________________ Referred by:___________________

In case of emergency, who should be notified: ____
(Name)

____
(Home #) (Work #) (Cell Phone #)

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Who is responsible for this account: ____
(Name) (Relationship)

Primary Insurance:_____________________________________Insurance Phone #:_____________

Claims Address for Mental Health Claims/ Payor #:_______________________________________

____
(Street) (City) (State) (Zip)

Name of Insured Person:______________________________DOB Insured Person:_____________

Address of Insured Person:____
(Street) (City) (State) (Zip)

Policy Number: ____ Group #:__________________

Authorization #:_____________________

Appointment Policy:
A no show/late cancellation appointment fee of $140.00 will be charged for sessions missed without twenty-four cancellation (not the co-pay or what your particular insurance would have paid for the session. Insurance carriers do not pay for missed appointments or late cancellations)

I understand and agree to the appointment policy.

Signature
Date

Credit Policy:
I understand that I am ultimately responsible for the balance on my account regardless of my insurance status. I certify that all information entered above is correct to the best of my knowledge. I understand that it is my responsibility to notify Amy McNulty, Ph.D. of any changes to the above information. I also understand that the failure to pay my bill in a timely manner or to make payment arrangements may result in the use of a collection agency. I understand that my demographic information, date of birth, social security number, nature of the services provided and the amount due may be given to a collection agency for the sole purpose of collection of funds.

I understand and agree to this policy.

Signature
Date

**I authorize direct payment from my insurance company to Amy McNulty, Ph.D. for professional services provided by her.

I understand and agree to this policy.

Signature
Date

Consent to Treatment:
I understand that no guarantees can or have been made to me regarding the results of treatment. I understand that I may stop this treatment at any time. I acknowledge that I have the opportunity to ask questions and receive clarification for anything stated in this document or about the treatment services which I am seeking.

Signature
Date