

Amy S. McNulty, Ph.D., MSW
309 South Sharon Amity Road
Suite 304
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 #)

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 \$150.00 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