KELLY WEDEVEN PLLC

1843 S Broadway Ave, Suite 103

Boise, ID 83706

Phone: (208) 841-2318 **www.kellywedeven.com** **Fax: (888) 977-1549**

CLIENT INTAKE FORM

(Please Print)

Today's Date _____/_____/_____ _____

CLIENT INFORMATION

Client's Name	Birth Date	Gender	Marital Status
		❑ M ❑ F	❑ Single ❑ Married ❑ Other

Street Address City State ZIP Code	Social Security	Home Phone No.
	- -	( )
Employer		Cell Phone No. ( )
Email Address:		

BILLING INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Relationship to Client	Client Covered by Insurance?	
❑ Self ❑ Spouse ❑ Child ❑ Other _____	❑ Yes ❑ No (Self Pay)	

Primary Insurance Company	Policy/Member Number: _____ Policy Holder: _____ Birth Date: _____
Secondary Insurance Company	Policy/Member Number: _____ Policy Holder: _____ Birth Date: _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

BILLING NOTICE

The insurance billing rate for a 55-minute session is $175 and initial intake is $195. We honor contractual agreements with insurance companies for specific reimbursement rates. Discounted rates are available for self-pay clients.

We are an in-network provider for some insurance companies and will bill insurance, if applicable. Copayments, self-pay and claims applied to a deductible are due at time of service. Please verify with your insurance company regarding copays and coverage.

There is a $50 fee for missed or late-cancelled appointments and $25 fee for checks returned for insufficient funds. Employee Assistance Programs (EAP) and Medicare are not accepted.

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CLIENT INTAKE FORM (Continuation)

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Kelly Wedeven PLLC will honor contractual agreements made with those insurance companies which stipulate specific reimbursement restrictions. I authorize the release of medical information for insurance purposes and assign payment of benefits to the provider of services.

X _____

CLIENT/GUARDIAN INITIAL DATE

I hereby consent to treatment by Kelly Wedeven. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop. I will give 48 hours' notice if I cannot make an appointment or I may be charged for the appointment. For more details, see Client Consent Information under Client Forms at www.kellywedeven.com.

x _____

CLIENT/GUARDIAN INITIAL DATE

PLEASE CROSS OUT ANY YOU DO NOT AGREE TO:

I give consent to receive billing statements or information through email.

I give consent to receiving phone messages or texts about appointments and/or payments.

x _____

CLIENT/GUARDIAN INITIAL DATE

I acknowledge that I have read or had the opportunity to read a copy of KELLY WEDEVEN PLLC Privacy Practices (available under Client Forms on the website). I understand that if I have any questions regarding the notice or my privacy rights, I can contact the Privacy Officer Mike Fisch at mike@kellywedeven.com or 208-863-8434.

x _____

CLIENT/GUARDIAN SIGNATURE DATE

CONSENT FOR TREATMENT OF A MINOR: We/I, the undersigned parent(s) and/or guardian(s) of a minor child _____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

x _____

PARENT/GUARDIAN SIGNATURE(S) DATE