Pitts & Associates **Adult Intake Form**

Patient's Name:_____ Date of Birth:_____ Gender_____

Street Address:_____

City: _____ State:_____ Zip:_____

Phone #1:_____ (text appt reminders) Phone #2:_____

Employed By: _____

Email Address: _____

Person Responsible for Payment:_____

Street Address:_____

City: _____ State:_____ Zip:_____

Phone #1:_____ Phone #2:_____

Social Security Number:_____ Employed By: _____

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PLEASE LET US KNOW TODAY if you are using your EAP for your initial visits. ☐Yes ☐No

If Yes, list EAP company name & auth no. _____

PRIMARY_____ SECONDARY_____

Policy Number_____ Policy Number _____

Subscriber's Name: _____ Subscriber's Name: _____

Birth date of Subscriber: _____ Birth date of Subscriber:_____

Relation to patient: _____ Relation to patient: _____

Employer: _____ Employer: _____

I have contacted my insurance company concerning the Mental Health benefits, co-pays and deductions for the patient as they pertain to my provider.

Signature _____Date_____
Patient or Responsible Party

I understand that, as a courtesy to me, Pitts & Associates files my insurance. I understand that Pitts & Associates is NOT responsible for keeping up with my insurance company's deductible, co-pays and/or the number of visits authorized by my Insurance. I also understand that my insurance company is NOT responsible for my bill, but that I am. If my insurance company does not pay in a timely manner, I will pay the bill in full.

Signature _____Date_____

Patient or Responsible Party

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I (We), the undersigned, hereby agree to pay all amounts and charges for services rendered by Pitts & Associates, Inc., no later than 30 days of the rendering of said services unless other specific arrangements are made. In the event of default of payment of said services, I (we) waive as to this debt all rights of exemptions under the constitution and laws of the State of Alabama, or of any other state, as to personal property, and agree to pay all costs of collection or securing or attempting to collect or secure said indebtedness, including a reasonable attorney's fee. I ALSO UNDERSTAND THAT UNLESS A CANCELLATION OF AN APPOINTMENT IS MADE 24 HOURS IN ADVANCE OF SAID APPOINTMENT, I WILL BE SUBJECT TO CHARGE FOR THE TIME RESERVED

Signature _____Date_____

Patient or Responsible Party

I authorize the release of any medical information necessary to process this claim and request payment to Pitts & Associates, Inc.

Signature _____Date_____

Patient or Responsible Party

Confidentiality agreement

You need to know that normally whatever you say or do during a counseling session will not be shared with anyone else without your written permission, with the following exceptions:

If you were referred by a specific agency, we may be required to furnish information to that agency.

If you were referred by a physician, it is customary to provide general progress reports to him or her. This will be done only if a consent form is signed by you.

I will keep brief written records of our sessions together. Under certain conditions, those records could be subpoenaed, and I would then be obligated to surrender them. This would not be done without your knowledge.

If you report to me that you are currently the perpetrator or victim of child abuse, elder abuse or molestation, I am required to report this to authorities. If you have questions about this, please ask for clarification.

If you indicate that you intend to harm yourself or someone else, I must act to notify potential helpers or victims.

If you are a minor, I must keep your parents informed of your progress, if they ask. Details of our conversations do not have to be revealed.

If you are in couple's counseling and you tell me something in private that affects your relationship with your Significant Other, I reserve the right to bring it up in couple's counseling, since it is my belief that our work together cannot be effective if the members of the couple are keeping secrets from one another.

I hope and trust that our time together will be helpful to you. Counseling can bring positive growth yet painful awareness. Please feel free to discuss your reactions to your counseling with me at any point. It is my belief that counseling clients should be encouraged to make their own informed choices about their lives, including the decision to continue in counseling.

Signature _____ Date _____

Client

Insurance Worksheet (for your use only)

For your convenience, insurance claims are filed by our office staff following your visit. You may be responsible for a co-pay or deductible amount at the time of service.

If you plan to use insurance to help pay for services at Pitts & Associates, you will need to verify your coverage for mental health services before the first session. We have included a form at the end of this document to assist you in this process. Contact information for your insurance provider is usually located on the reverse side of your insurance card.

The following insurance companies are accepted by one or more of our clinicians. Please contact your insurance provider to verify your coverage.

Blue Cross Blue Shield of Alabama
Federal Blue Cross Blue Shield
Medicaid
American Behavioral
Behavioral Health Systems
TriCare
Out of State Blue Cross Blue Shield
Medicare
United Behavioral Health/OPTUM
Aetna
Cigna

Questions to ask your insurance company before your first visit with us:
(Bring this completed form with you to your first appointment)

What are my outpatient mental health benefits?_____
_____
_____

What is my yearly deductible? _____ Has it been met yet? _____

What is the renewal date for my benefits? _____

What is my co-pay once the deductible has been met? _____

Is authorization required? If so, what is my authorization number? _____

How many visits does this authorize? _____

What needs to be done to request additional visits? (Clinician send in treatment plan?)_____

Where? fax number or address _____

Where are insurance claims mailed? _____
_____
_____

PLEASE UNDERSTAND. Your insurance will NOT cover any charges for missed appointments or late cancellations (less than 24 hours advance notice).