JACK JESSUP, LP-MA
CLIENT INTAKE FORM

First Name: _____ Last Name: _____

Date of Birth: _____ Mailing Address: _____

City: _____ State: _____Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

I understand that confidentiality is important. What is the best way to contact you:

If under 18, parent or guardian's name: _____

Mailing Address: _____

City: _____ State: _____Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

If different than above, person to contact in case of emergency:

Home Phone: Work Phone: Cell Phone:

PRIMARY INSURANCE INFORMATION

Subscriber Name: _____ Subscriber's Date of Birth: _____

Relationship to Client: _____ Insurance ID #: _____

Insurance Group #: _____ Insurance Name and Phone: _____

SECONDARY INSURANCE INFORMATION

Subscriber Name: _____ Subscriber's Date of Birth: _____

Relationship to Client: _____ Insurance ID #: _____

Insurance Group #: _____ Insurance Name and Phone: _____

ASSIGNMENT AND RELEASE

- I hereby authorize my insurance benefits to be paid directly to Jack Jessup and acknowledge that I am financially responsible for all balances not paid by my insurance company.
- I also authorize the release of information needed to verify the medical necessity for my evaluation and treatment to my insurance.
- If client is a minor, my signature below attests that I have legal responsibility to make healthcare decisions for the above named minor.
- I agree to pay a cancellation fee of _____ if appointments are not cancelled 24 hours in advance.

Signature: _____ Date: _____