Psychotherapy Services with Michael R. Kandle, Psy.D.

CLIENT INFORMATION

Name of Client: _____ Date of 1st Visit _____

Date of Birth _____ Age _____ Marital Status _____

Address _____

Town/City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____

E-mail Address _____

Household Members:

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

If client is a student; Name of school _____ Grade _____

From whom or where did you receive my name? _____

Name of Physician _____ Town/City _____

Medications _____

Have you received mental health care in the past? Yes _____ No _____

Significant health issues _____

Insurance Information

Insurance Carrier

Member ID #

Name of policy holder

Policy holder's DOB

Agreements

Consent to Treat a Minor (if applicable)

If client is a minor, I authorize Michael R. Kandle, Psy.D. to treat my minor child(ren).

Minor child(ren) name(s)

Parent/guardian electronic signature — type full legal name

Date

☐ By checking this box, I agree that typing my name above constitutes my electronic signature and confirms my agreement to the consent stated above.

Insurance Authorization and Assignment of Benefits

I authorize Michael R. Kandle, Psy.D. to bill my insurance company and to have benefit payments assigned to him. If my insurance company requires clinical information to authorize treatment or process my claim, I consent to the disclosure of information reasonably necessary for that purpose. My psychologist will notify me in advance if the insurance company requests additional clinical records or detailed treatment information beyond what is ordinarily required for billing. I understand that declining such a disclosure may affect my insurance coverage.

Patient / authorized representative electronic signature — type full legal name

Date

☐ By checking this box, I agree that typing my name above constitutes my electronic signature and confirms my agreement to the consent stated above.

Instructions following completion of form

1: At top right corner click on the download icon

2: Select "With Changes" if prompted

3: Save as "Kandle Intake"

4: Attach document to an email and send to drmichaelkandle@gmail.com