BETSY MADDEN-ECHOLS, LICSW
4 Wampanoag DRIVE, PORTSMOUTH, RI 02871 PHONE: 401-683-5386 FAX: 401-683-0232

INTAKE INFORMATION Who referred you?_____

Name: _____Your Birthdate: ___/___/_____
Address: _____City_____State:_____Zipcode:_____
Phone: (____)_____Work_____Cell_____
Employer:_____If student, school name_____

Marital Status_____married___single___divorced___separated___living with partner____other.
Spouse/partner/parents name_____Birthdate _____Employer_____
Children's names/birthdates_____
Living at home?_____
Emergency Contact_____Phone_____

HEALTH INSURANCE
Insurance Company_____ID Number_____
Authorization # (if applicable)_____Group #_____
Subscriber's name and employer_____Birthdate of Subscriber___/__/____
Other health coverage, Insurance company name_____ID #_____

Primary Care Physician_____Address_____
PLEASE LIST ANY MEDICATIONS YOU ARE TAKING AND START
DATES:_____
_____
Prescribed by whom?_____

PLEASE NOTE AND SIGN BELOW TO INDICATE THAT YOU HAVE REVIEWED AND ACCEPT THESE POLICIES:

-SESSIONS ARE 50 MINUTES IN LENGTH
-CONFIDENTIALITY IS MAINTAINED IN ACCORDANCE WITH THE LEGAL STATUTE LIMITATIONS

-24 HOURS NOTICE IS REQUIRED FOR CANCELLATION OR YOU WILL BE CHARGED IN FULL FOR THE SESSION AMOUNT. Your insurance company cannot be billed for any part of the fee when a session is not kept or not cancelled 24 hours prior.

-In the event that your insurance company coverage is not valid or proper authorization was not obtained, all charges will be your responsibility.

I GIVE YOU PERMISSION TO CONTACT MY DOCTOR NAMED ABOVE TO RECEIVE AND EXCHANGE INFORMATION REGARDING MYSELF OR MY CHILD_____(NAME)

Signature_____Date_____