Intake Form

Name		**Date of Birth**
Couple Counseling only: Spouse/Partner's Name		Date of Birth
Street Address	**City, State**	**Zip**
Couple Counseling only: Spouse/Partner's Address, if different	City, State	Zip

How did you hear about me?

☐**Psychology Today Listing** ☐**Pauljlachance.com Website** ☐**Referred by:**

Children:

_____ Age_____☐Living Together ☐ Apart*

_____ Age_____☐Living Together ☐ Apart*

_____ Age_____☐Living Together ☐ Apart*

_____ Age_____☐Living Together ☐ Apart*

***Child/Children's address:**

Primary Contact information: **Indicate whether you prefer to be contacted by phone or by email.**

	Preference		**Preference**
Phone:	□	**Email:**	□

Primary Contact information: **Indicate whether you prefer to be contacted by phone or by email.**

	Preference		**Preference**
Phone:	□	**Email:**	□

If you give me permission to send emails, I may send information and updates related to my practice and handouts or weblinks which we discuss and that may be of interest to you in support of your treatment. I will not use email or text for treatment purposes other than pre-arranged reminders. Be aware that text and email may not be secure, and I cannot guarantee the privacy of the information you send to me or receive from me.

Insurance Form and Good Faith Estimate

Please complete this form to obtain a best estimate of the cost of therapy.
As I am not in network with insurance carriers, your actual costs for therapy will be based on the reimbursement or contribution made by your insurance carrier toward the session fee.

Client Name	Date of Birth
Insured Member, if not the client	Date of Birth
Insured Member's Address	
Insurance Company Name	Plan or Program Name
Insured's ID number	Group or FECA number

NOTE: Carriers pay for a percentage <u>of what they allow</u> for therapy. This allowed amount may be less than my session fee. The maximum out-of-pocket for which you are responsible is $120 per session.

My out-of-network (OON) deductible is $_____ toward which I have been credited $_____ this year.

The <u>allowable charge</u> for the procedure code for the counseling I will be receiving is:

- 90837 Individual Psychotherapy $_____
- 90847 Marriage/Couple Therapy $_____

After meeting my deductible the insurance carrier will contribute _____% of _____ (the allowable charge).

After meeting your deductible, your therapy will cost approximately $120 less the actual amount reimbursed by your insurance carrier (the percentage of the allowable charge). Estimated cost per session:

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Paul J. LaChance, PhD

Licensed Professional Counselor

409 Main St., Chester, NJ 07930 | 133 North Fourth St, Easton, PA 18042
908.235.8489 | pjlachance@outlook.com

CREDIT CARD INFORMATION TO KEEP ON FILE

Payment is due at the time of service. The information you provide here will be used to collect fees for virtual sessions. In the event you must cancel an appointment, please give me 24-hours' notice. If we are able to reschedule within the same week, no fee will be charged. Otherwise, you are responsible for the full amount, which may be charged to this credit card. If you prefer to pay for sessions by cash or check, a 4% discount will be applied.

Client Name: _____

Cardholder's Name: _____

Card # _____

Expiration Date: _____ I will ask for the security code in session.

Billing Zip Code: _____

If you would like to receive an emailed receipt, please provide an address:

_____

Cardholder's or Authorized Signature: _____ Date: _____