

Debby Rubenfeld, MSW
7643 Leesburg Pike
Falls Church, VA. 22043
License #0904-003314

INITIAL INTAKE AGREEMENT

Today's Date: _____

Patient's Name _____

Social Security # _____

Date of Birth _____

How shall I reach you? Home # _____ Work # _____ Cell# _____

E-Mail: _____

Address _____

Zip _____

I accept some forms of insurance. To bill insurance, please call the number on the back of your card in advance of our first meeting to ascertain 1) your mental health deductible, 2) your co-pay amounts per/ session, 3) your precertification number for outpatient mental health visits. Co-payments and payments are expected in full on session dates. Thanks!

Precertification Number _____

Insurance Company _____

Mailing Address _____

Phone # _____

Subscriber's Name _____

Relationship _____

ID# _____

Group/Policy # _____

Employer/Group Name _____

PLEASE READ THIS CAREFULLY.

CANCELLATION POLICY: Clients are responsible for scheduled appointments. When an appointment is cancelled on short notice, I cannot bill insurance for the time and it may not be possible to schedule someone else. I agree to work with you on the understanding that \$115 for 50 minutes is charged to you for cancelled appointments that are not rescheduled for that same week. I am more than happy to accommodate reasonable rescheduling requests for vacations and business trips and am most able to with at least one week's notice. If you or I are unable to reschedule a missed appointment, initialing here and signing below signifies an agreement to pay \$115. I may raise my fee annually.

My Initials Here Indicate I Have Read, Understood, and Agree to the Terms of This Policy :

X _____

I authorize Debby Rubenfeld, MSW to apply for payment on my behalf. I request payment from _____ (ins. co.) to be made to her. I certify that the information I have reported above is correct and further authorize its release and that of medical records if required to the above named insurance company in determining to which of their benefits my policy entitles me. I may revoke this consent in writing. I accept full responsibility for all charges whether or not paid by said insurance. In the unlikely event of account default, I accept full responsibility for all attorney and collection fees.

Signature of Party Responsible for Payments _____

Date _____

Printed Name _____