Tali Moskowitz, LCSW

CLIENT INTAKE FORM

1800 Rockaway Ave., Suite 206
Hewlett, NY 11557
(516) 619-6405
tali@talimoskowitzlcsw.com
talimoskowitzlcsw.com

Today's Date ______/____/______

CLIENT INFORMATION					
Name Last First	Title (Mr. Ms. Mrs.)	DOB	AGE	SEX Male ☐ Female ☐	
Street Address	City	State	Zip Code		
Marital Status Single ☐ Married ☐ Separated ☐ Divorced ☐ Domestic Partnership ☐ Widowed ☐	Occupation	Employer	Social Security #		
Referred to Provider By Friend ☐ Family ☐ Internet ☐ Website ☐ Other_________________	Work Phone Leave Msg?	Cell Phone Leave Msg?	Home Phone Leave Msg?		

INSURANCE INFORMATION				
Person Responsible for Bill	DOB	Street Address	City	
Are your visits covered by Insurance?	How many allowed visits per year?			
Occupation of Insured	Employer	State	Zip Code	Social Security Number
Street Address	City	State	Zip Code	
Email Address - Receive Statement Via Email Yes ☐ No ☐				
Insurance Carrier	Policy Number	Group Number	Co-Payment $	

EMERGENCY CONTACT INFORMATION			
Name of Contact	Relationship To Client	Home Phone	Cell Phone
Name of Contact	Relationship To Client	Home Phone	Cell Phone

REQUIRED SIGNATURES

Payment Obligations:

I clearly understand that I am ultimately responsible for payment for any and all services rendered due at the time of the visit or upon receiving explanation of benefit information from my insurance company, whichever comes first. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. I understand that if I should default on any payment obligations as called for in this agreement, Tali Moskowitz, LCSW will have the right to forward my information to collections, and in the event that it becomes necessary to utilize a collection agency to resolve a past due account, an additional fee may be assessed to my account to cover the costs of this action.

My signature below indicates that I fully understand and agree to these terms.

BILLING SIGNATURE(S)(LEGAL GUARDIAN) – Required for services	DATE

INFORMED CONSENT:

My signature below indicates that I am consenting to treatment by Tali Moskowitz, LCSW., and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPAA). If I have questions, the information has been explained and/or summarized for me.

SIGNATURE(S)(LEGAL GUARDIAN) – Required for services	DATE

I authorize Tali Moskowitz, LCSW, to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Tali Moskowitz, LCSW. I understand that I am responsible for payment for services rendered regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify Tali Moskowitz, LCSW, immediately whenever I have changes in my health condition or health plan coverage in the future.

SIGNATURE(S)(LEGAL GUARDIAN) – Required to bill insurance	DATE