

PAUL G. JOSELL, Psy.D.
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INTAKE FORM

Client Name _____ SS# _____
(First) (Middle) (Last)

Birthdate _____ Gender _____ Home Phone _____ Cell Phone _____

Address _____
(Street) (City) (State & Zip)

Employer _____ Business phone _____

Email Address (only used if authorized) _____

Marital Status _____ How did you hear of me? _____

Spouse's Name _____ Birthdate _____

Spouse's Employer _____ Business phone _____

Person Responsible for Payment _____ How Related _____

Person to contact in case of emergency:

Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION
(may be skipped if insurance card is copied)

Name of Primary Medical Insurance _____

Address for claims _____

Contract/Certificate # _____ Group # _____

Secondary Insurance _____

Address for claims _____

Contract/Certificate # _____ Group# _____

AUTHORIZATION TO FILE INSURANCE/ FINANCIAL RESPONSIBILITY STATEMENT

I hereby authorize said assignee to release only information necessary to secure the insurance payment. I hereby assign all medical benefits, including any major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to **Paul G. Josell, PSY.D.** This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signed _____ Date _____