Insights, Inc

703 N. 8TH STREET, SUITE 202, SHEBOYGAN, WI 53081

PATIENT INTAKE

Name:_____DOB:_____

Address:_____

City, State, Zip:_____

Phone:(H)_____(Cell)_____

(W)_____School/Job_____

If we may contact you by email, please give address:_____

Responsible Parent/Guardian:

Mother's Name:_____Cell:_____

Father's Name:_____Cell:_____

Presenting Problem:_____

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Referred by:_____

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Therapy Fees:

Initial Consultation (Evaluation & Diagnosis)	60 min session - $115
Individual & Family Therapy	60 min session - $100
School or Home Visits	(door to door) - $100/hr
Phone Therapy / Skype	60 min session - $100

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APPOINTMENTS MUST BE CANCELLED 24 HOURS IN ADVANCE . WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS NOT CANCELLED DURING THOSE HOURS.

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I have read the cost of treatment shown above and agree to the terms.

*Signed*_____*Date*_____

(Patient, Parent, Guardian)

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All credit card information will be securely stored in your clinical file and may be updated at any time. All transactions will read ***"Therapy Partner Corporation"*** *on your bank or credit card statement. Therapy Partner is the merchant who processes our credit card transactions. Monthly statements will be emailed to you. After your first payment, this bottom portion is destroyed and only the last four digits remain on file.*

Payment Options: Visa MasterCard Discover Check or Cash

Credit/Debit Card Number:_____

Expiration Date:_____