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INTAKE FORM

A. PERSONAL INFORMATION

Patient Name _____ Date of Birth _____
Address _____ Gender ☐ Male ☐ Female
City/State/Zip _____ Marital Status _____
Home Phone ( ) _____ Cel Phone ( ) _____ Work Phone ( ) _____

B. RESPONSIBLE PARTY (who is the insured person?)

Name _____ Date of Birth _____
Address _____
City/State/Zip _____
Home Phone ( ) _____ Work Phone ( ) _____
Relationship to Patient _____

C. INSURANCE INFORMATION

Primary Insurance Company _____
Address _____
City/State/Zip _____
Phone ( ) _____
Name of Insured (if different from patient) _____
Insurance ID# _____ Group # _____

Secondary Insurance Company _____
Address _____
City/State/Zip _____
Phone ( ) _____
Name of Insured (if different from patient) _____
Insurance ID# _____ Group # _____

D. INSURANCE COVERAGE INFORMATION

Annual Deductible _____
Insurance Coverage per session ☐ 100% ☐ 80% ☐ 50% ☐ Other _____
How much coverage per calendar year? $_____ or Number of Sessions _____
Co-payment per session $ _____ Other _____

(continued on other side)

Mark a. Karpel, Ph.D.
Intake Form page 2

E. AUTHORIZATION INFORMATION

Authorization # _____ Number of Sessions Authorized _____
Date Authorization Starts _____ Date Authorization Ends _____
For Authorization Call ( ) _____ Ext. _____ FAX ( ) _____

RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize the release of any medical or other information necessary to process insurance claims.

Signed _____ Date _____

I authorize payment of medical benefits to my provider for services performed.

Signed _____ Date _____