Glenn Marron, Ph.D. PLLC

• 280 Madison Ave suite 805, New York, New York 10016 • Tel: 917 608-8482 Fax (212) 922-1660 • glennmarronphd@gmail.com •

PATIENT INTAKE FORM

Name_____Email_____
Policy Holder's Name (if different)_____
_____
Work Phone_____Cell_____Home_____
Student ID (If applicable)_____
Date of Birth_____SS#_____
Emergency Contact:_____
Phone_____
Address_____
Primary Care Physician_____
Phone_____ Email _____

You Must Get Copies of The Front and Back of Your Insurance ID

DX_____

POLICY EFFECTIVE DATE _____

YEARLY DEDUCTIBLE _____

HAS DEDUCTIBLE BEEN MET? _____

HOW MANY SESSIONS ALREADY USED THIS YEAR? _____

COPAY OR COINSURANCE _____

AUTHORIZATION # _____

CLAIMS MAILING ADDRESS _____

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FEE POLICY (Please Read Carefully)

I am aware that I am responsible for the **full payment of any appointment** for which I have not cancelled by calling Dr. Marron's cell phone (917-608-8482) **and** emailing her at least 48 hours in advance (and for Monday appointments, by the previous Friday at 6:00pm.) Texting alone will not suffice. For managed care insurance patients, this includes co-pay PLUS insurance company's portion.

Furthermore, I understand that frequent cancellations will affect the availability of regularly scheduled appointments. And unless previous plans have been made, if I haven't had an appt. for 2 consecutive weeks, I understand that Dr. Marron will likely accept a new patient in my absence. This is to allow other patients an opportunity to begin therapy when there is an unexplained or prolonged absence by existing patients.

I take responsibility for all procedures and provisions of my particular insurance plan and will be responsible for all fees and costs that go along with those provisions. (In the case of students or dependents, a parent or legal guardian must sign to accept responsibility for payments not made on the date of visit. Please sign below to accept financial responsibility for all psychotherapy costs.)

In the event that contact with other professionals, family, with you or with others is needed as part of your therapy, there are fees (not covered by insurance) for any calls that last longer than 15 minutes or detailed emails, particularly if there are multiple contacts necessary during treatment (this charge does not apply to initial contacts with you). Fees would be pro-rated according to time spent in these communications.

Either full fee or copayment is due *on the date of service* by cash or check

STUDENT PATIENTS: for parents who decide to cover therapy payments, for clinical and administrative purposes, **all payments must be made by the patient him/herself at each visit**. If parents are involved financially, please make arrangements to manage funds with your child prior to beginning treatment.

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Thank you.

Person Responsible for Fee _____

Signature_____ Date _____

Parent Signature if applicable:_____ Date_____

Card Type:	Visa / MasterCard / American Express / Discover
Name on Card:	
Billing Street Address:	
City/State/Zip Code:	
Card Number:	
Expiration Date:	
Security Code:	