Glenn Marron, Ph.D. PLLC

• 280 Madison Ave suite 805, New York, New York 10016 • Tel: 917 608-8482

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 _____

I, _____ (print name), take responsibility to inform Dr. Marron of all of the following information *every year at the beginning of the new insurance cycle or starting a new job*. **This requires that I speak directly with a representative and include their name, direct phone number, and date of call.**

- Name of Insurance Representative: _____
- Insurance Representative Contact Number: _____
- Date of call: _____
- Policy Effective Date _____
- Yearly In-Network Deductible _____
- Has deductible been met and when _____
- Co-pay and co-insurance _____
- Claims Mailing Address _____
- **Name of plan and type of plan (e.g.: PPO, EPO, HMO, etc.) - Please provide a photo of updated insurance ID card (front and back)**

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_____

_____

- 1. Whether Dr. Marron participates in my plan _____
- 2. Whether you are allowed to see me out of state (and under what terms) if you are in a different state than I am _____
- 3. Does your insurance cover teletherapy, including out of state? _____

Any failure to fully know and comply with the above puts the fiduciary responsibility on you for anything that is not remitted by your insurance company.

FEE POLICY (Please Read Carefully)

I am aware that I am responsible for the **full payment of any appointment** for which I have not canceled 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 appointment 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. (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 I need to have contact with other professionals, family, and/or all others who are involved in your care, my pro-rated private fees apply for time spent in these calls/emails (not covered by insurance). They apply to any calls that last longer than 15 minutes for one call (or 10 minutes if more than one call is necessary). If emails are required related to your therapy and/or due to unresolved insurance issues, there may be additional fees applied here as well.

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

<u>For both Private pay and Insurance Patients</u>, full fee or copayment is due *on the date of service* by Zelle or check. Failure to submit such payment will create potential additional fees per day of non-payment.

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:	