Dan N. Short, Ph.D.
9855 E. Larkspur Dr.
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Clinical Psychologist
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Intake Information

Name _____ Male ____ Female ____

Address _____ City _____State _____ Zip _____

Telephone (1) _____(2) _____(email)_____

Age _____ DOB _____ /_____ /_____ Occupation _____

Partner's name _____ Age _____ Occupation_____

Children (name/age)_____

Referral source (name)_____ Medical or Psychiatric Conditions _____

Name/dosage of the medication(s) _____

Medication(s) prescribed by _____

Have you previously received therapy or counseling Yes _____ No _____ Dates: _____

Insurance Information: Primary Insurer: ___ **MCB**, ___ **Magellan**, ___ **Mayo MMSI**; ID#: _____

Insured's Name: _____, DOB _____ /_____ /_____ , Relation: _____

** Note: If your insurer is not one of three listed above, you will need to pay the full fee up front, claim forms for out-of-network benefits/direct reimbursement, will be provided. **Those with MCB will be asked for a credit card number to cover any deductible or supplementary fees.*

Confidentiality: All communication between patient and psychologist will be held in confidence unless written consent for release is obtained, with few exceptions: psychologists are compelled by law to inform appropriate other person(s), including legal authorities, if there is evidence that a patient is in danger of creating serious bodily harm to self or someone else, or if there is reasonable suspicion a child has been abused. Records may also be released as a result of a court order. These situations have rarely occurred in my practice. Finally, some managed care plans require verbal and/or written treatment information from the care provider.

Office Policies & Procedures: Therapy sessions are 50 minutes, with rescheduling. Payment is due at the beginning of each session. The fee for one session is $140. Other services, including telephone calls of more than 10 minutes, are charged at the same rate. You may use insurance, however, you remain responsible for any co-insurance, deductible or non-covered services. You will be charged a $50 fee for all missed appointments unless you provide 24-hour advance notice, this is not covered by insurance. You will be charged a $10 fee for each returned check. I am often not immediately available by telephone. Phone messages are returned by the next business day. If you are experiencing a crisis and need immediate assistance, you should call the local 24 hr. crisis hotline (480) 784-1500 or 911.

Insurance Authorization & Receipt of Privacy Notice: I authorize my insurance to make payments directly to Dr. Dan Short for services I receive. I have read the information regarding financial arrangements in the paragraph above. I understand that I am financially responsible for all charges incurred by me during the course of treatment, regardless of any insurance coverage I may have. I acknowledge that I have been offered a copy of the office's Notice of Privacy Practices (HIPAA).

Your signature below means that you have read and understand the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Client or legally authorized signature Date