Kimberly A. MacEachern, PsyD
Clinical Psychologist (PY60535554)
316 Main St, Ste A4
Edmonds, WA 98020
425-362-4028

Intake Form

Client/Patient Demographic Information

First Name: ______________________________
Middle Initial: ______________________________
Last Name: ______________________________
Date of Birth: ______________________________
Social Security Number (Optional): ______________________________
Sex: M F Identified Gender:_______________ Sexual Identity:________________
Marital Status:_______________Ethnicity:______________________________
Address: ______________________________
City:______________________________
State: ______________________________
Zip Code: ______________________________
Phone Number: ______________________________
Email Address: ______________________________
Referring Physician Name (Optional): ______________________________
Referring Physician Phone Number (Optional) : __________________________

Insurance Information

Primary Insurance Company: ______________________________
Subscriber ID # (including letters): ______________________________
Group Number: ______________________________
Secondary Insurance Company: ______________________________
Subscriber ID # (including letters): ______________________________
Group Number: ______________________________
Insurance Policyholder Full Name: ______________________________
Insurance Policyholder Date of Birth: ______________________________
Insurance Policyholder Address: ______________________________
Insurance Policyholder Relationship: Self Spouse Child Other
Insurance Policyholder Social Security Number: ______________________________
Insurance Policyholder Sex: M F

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Emergency Contact

Name	Relationship	Contact Info

Authorization to Contact

What number can Kim MacEachern, PsyD leave a message on:

☐ Yes: ______________________ ☐ No

Can Kim MacEachern, PsyD email you? If so, please list preferred email:

☐ Yes: ______________________ ☐ No

Can Kim MacEachern, PsyD leave a message with a partner/spouse?

☐ Yes ☐ No

By providing the information listed above, I authorize Kim MacEachern, PsyD to contact me through the approved methods listed above. I reserve the right to revoke this consent by providing Kim MacEachern, PsyD written notice.

Signature: ______________________ Date: ______________

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Patient Authorization

I authorize the release of any medical and insurance information necessary to process any claim.

Patient Signature: ____ Date: ___________
Signature of Financially Responsible Party: ________________________________
Date: ___________
Patient Full Name: ____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician, if a referral is required by my insurance plan. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: ____ Date: ___________
Signature of Financially Responsible Party: ________________________________
Date: ___________
Patient Full Name: ____

** Note: All signatures are required.*

Financial Responsibility

I authorize provider to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies including: copays, coinsurance, deductibles, insurance plan refusal to pay for failure to obtain authorization, and missed and late cancellation fees.

Signature of Financially Responsible Party: ____
Date: ___________________