TEMPO GROUP, INC.

□112 Franklin Place, Woodmere, NY, 11598 (516)374-3671
□1260 Meadowbrook Rd., N. Merrick, NY, 11566
□23 Willis Avenue, Syosset, NY, 11791

Initial Intake Form (* fields are required)

Patient Information

Patient's Name*	SS#*	DOB*	Sex M( ) F( )
Address* Zip Code* City State	Home* Cell* Work*	Insurance Company* ID Number*	
Email Address			

Parent/Guardian/Partner Information

CIRCLE ONE: I am the Parent/Guardian/Partner/Other of the Patient listed above.

Name*	SS#*	DOB*	Sex M( ) F( )
Address* Zip Code* City State	Home* Cell* Work*	Insurance Company* ID Number*	
Email Address			

CIRCLE ONE: I am the Parent/Guardian/Partner/Other of the Patient listed above.

Name*	SS#*	DOB*	Sex M( ) F( )
Address* Zip Code* City State	Home* Cell* Work*	Insurance Company* ID Number*	
Email Address			

RELEASE OF INFORMATION, BENEFIT OF ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSER STATEMENT AND AGREEMENT TO PAY PROFESSIONAL SERVICES

1) Regardless of insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I the parent/guardian agree to pay such fees in full.
2) The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled.
3)I/the parent/guardian understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe will result in full liability for professional charges, as a result of non-payment by any carrier.
4)I/the parent/guardian hereby authorize TEMPO GROUP to release any information necessary to process my or my minor's insurance, acquired in the course of his/her treatment; to allow a photocopy of my signature to be used to process my or my minor's insurance for a period of a lifetime.
5) I/the parent/guardian authorize and direct my insurance carrier to assign payment for services rendered (such as Individual, Group, Family or psychiatric visits) directly to TEMPO GROUP. If the insurance carrier issues payment directly to the insured, then it is my responsibility to assign payment of check or reimburse Tempo Group for the equivalent amount.

________________________	____________________________________	__________________________________
PATIENT SIGNATURE*	PARENT/GUARDIAN/PARTNER SIGNATURE*	PARENT/GUARDIAN/OTHER SIGNATURE*
DATE_____________	DATE___________	DATE_____________

FOR OFFICE USE ONLY:

Case #:	Intake Worker 1:	Intake Worker 2:	Intake Date:	Location:

Revised 02/2015