Self Care Solutions
June Kiefer, MSN, RN, PHMCNS-BC
18 Lakecrest Lane
Ronkonkoma, NY 11779
631-981-8807

Intake and Financial Agreement

Client Name: ____

Date of Birth: ________________________________ Age: ___

Race: ________________________ Gender: _______________ Marital Status:________________

Children: ____________________________________ Legal Issues: _________________________

Occupation: ____

Home Address: ____

____

Phone Number: ____

Reason for Visit: ____

____

____

Previous Treatment: ____

____

Medications: ____

____

Physical Limitations: ____

Name of Financially Responsible Party: ____

Relationship to Patient: ____

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I understand and agree that my insurance will be billed for services rendered. I agree to release my identifying information as well as treatment and insurance information in order to facilitate insurance processing. I assign all insurance benefits for this treatment to Self Care Solutions/June Kiefer. I understand that I will be responsible for the self-pay rate of $125.00 should my insurance refuse payment.

If I do not have insurance or June Kiefer is not in network with my insurance plan, I agree to the hourly (50 minute session) rate of $125.00.

I will make every effort to keep all appointments and will arrive on time. Should it be necessary to cancel an appointment, I will give at least 24 hours' notice. If I do not keep my appointment and do not call within 24 hours, I will be responsible for a $50.00 no-show fee.

Printed Name: ____

Signature: ____ Date: _________________