Giovanna M. Cammuso, LCSW
312 Main St. Southington, CT 06489
(860) 919-7136 / GMC.LCSW@gmail.com

CLIENT INTAKE FORM		
Patient's Full Name (Last, First, MI):		
Maiden Name (if applicable):	DOB:	SSN:
Current Address:		
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	Email:
Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Cohabiting	Highest Grade of School Completed:	
Armed Forces Veteran: ☐ YES ☐ NO	Do you have children/dependents? ☐ YES, age(s): ____________ ☐ NO	
CAREGIVER/GUARDIAN/CONSERVATOR INFORMATION (IF APPLICABLE)		
Does the above-named patient currently have a caregiver/legal guardian (if under 18), or court-appointed conservator?: ☐ YES ☐ NO		
Caregiver/Guardian/Conservator Full Name:		
Relationship to Patient:	Phone:	Fax:
Current Address:		
City:	State:	Zip Code:
MEDICAL INFORMATION		
Primary Care Physician (PCP) Name:		
PCP Address:	PCP Phone:	
City:	State:	ZIP Code:
In the event of an emergency requiring hospital referral, what is your preferred hospital?:		
EMERGENCY CONTACT INFORMATION		
Emergency Contact Full Name:		
Home Phone:	Cell Phone:	Relationship to Patient:
EMPLOYER INFORMATION (NOTE: NO INFORMATION CAN BE DISCLOSED TO YOUR EMPLOYER WITHOUT YOUR PRIOR WRITTEN CONSENT)		
Current employer:	Employed Since:	
Employer Phone:	Position Title:	Hours Per Week:
HEALTH INSURANCE INFORMATION		
Health Insurance Provider:	Contact Person (if any):	
Insured's Name (Last, First, MI):	Relationship to Patient:	
Insured's Address:	Insured's Phone:	
Insured's DOB:	Insured's SSN:	Insured's Employer:
Member ID#:	Group#:	Other ID# (if any):

REFERRAL SOURCE/OTHER INFORMATION	
Referral Source (if other than self):	Phone:
Probation/Parole Officer? / DCF Worker?: ☐ NO ☐ YES, Name:	Phone:
SIGNATURES	
By applying my signature, I certify that all information entered on this form is accurate and complete to the best of my knowledge.	
Patient Signature:	Date:
Caregiver/Guardian/Conservator Signature:	Date:

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** If there is other insurance to cover this patient, print information on the back of this form.

Beneficiary/Guarantor Signature (Initial and Sign)

________ I request that payment of the authorized insurance, Medicaid, and Medicare benefits be made on my dependents or my behalf to Giovanna Cammuso, LCSW for the services furnished me or my dependents by the provider. I authorize any holder of medical information about my dependents or myself to release to the Centers for Medicare and Medicaid Services and its agents or my insurance company any information needed to determine the benefits payable for related services.

______I understand that even though Giovanna Cammuso, LCSW or her agent will submit claims to my insurance, I am responsible for the portion of my bill considered to be my insurance co-payment, coinsurance, deductible, or other charges not covered by insurance including non-payment for my failure to comply with insurance guidelines regarding prior authorization of treatment related services. .

______ I understand there will be a charge for late cancellation (less than 5 hours) or failure to show for an appointment. This is not covered by insurance.

Strict 5 HOUR CANCELLATION POLICY:

Please understand that your insurance does not cover sessions that you do not attend. Therefore it is important that you notify me within 5 hours if you will be unable to attend your session. Sessions cancelled with less than 5 hours advance notice are subject to the **option of being Charged $50.00 or being discharged** from receiving psychotherapy services by Giovanna M. Cammuso, LCSW, with a referral to a new psychotherapist.

Should you have any questions, please ask when we meet.

Signature____________________________________ Date ______________________________

Signature of Beneficiary/Guarantor