



Turtle Dove Counseling

Hood River Hypnosis & DBT

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INTAKE FORM & FEE AGREEMENT - WOMEN'S DBT GROUP

NAME: _____
 First Middle Initial Last

DATE: _____

ADDRESS: _____
 Street City State Zip

TELEPHONE: Home : _____ Cell: _____ D.O.B.: _____ Age: _____

Email: _____

By providing your email address you are giving permission for email communication.

REFERRING PRIMARY THERAPIST: _____

PERSON TO CALL IN EMERGENCY: _____
 Name Number

MARITAL STATUS: _____ Former/Present marriage(s) (years): _____

FEES INSURANCE: \$150 intake billed to insurance. \$45 for each group, billed to insurance.

COPAY: Waived for group if you have Medicare insurance, or if specifically requested.

Copy both sides of Card or:

Name of INSURANCE CO.: _____

Address of INSURANCE CO.: _____

Insured's Name: _____ **Insured's DOB:** _____ **SSN #** _____

Plan # _____ **Group #** _____ **Medicare #** _____

Insured's Employer _____

24-hour cancellation is required if you are unable to attend a scheduled appointment.
Appointments cancelled with less than 24 hours or missed without explanation will be charged a **\$25.00 fee.**

Signature of Responsible Party: _____

[] I have read and received a copy of HIPAA form on the reverse.