Deedee Shaw LICSW
330 North 48th St, Suite A
Lincoln, NE 68504-3515
Phone 402-326-9168

CLIENT INTAKE FORM

Last Name _____ First Name _____ Middle Name _____

Address _____

Phone _____ Email _____ D.O.B. _____

Gender _____ Single Married Separated Divorced Widowed

Employer / School _____ Phone _____

Parent / Spouse Name _____ Phone _____

Emergency Contact _____ Rel. to Client _____ Phone _____

Referred by _____ Have you had previous counseling? Y or N Psychiatrist Y or N

Reason for visit _____

Primary Care Physician / Office _____

Phone _____ Email _____ Fax _____

Do you have Medical Insurance? Y or N If yes, please answer ALL questions below

Primary Insurance Company

_____

Policy Number _____ Group Number _____

Does your insurance require prior authorization? Y or N If YES, have you contacted the company? Y or N

Policy Holder's Name _____ Rel. to Client _____

Address _____ Policy Holder's DOB _____

Gender _____ Phone _____ Email _____

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CLIENT INTAKE FORM

Responsible Party / Guarantor (If other than Client) _____

Address _____ Phone _____

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my provider to submit claims for benefits for services rendered without obtaining my signature on each claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Infinite Change Family Therapy Center that is otherwise payable to me for his/her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to individual providers will be credited to my account in accordance with the above assignment.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

Relationship to Patient _____

Witness Signature _____ Date _____