Intake & Insurance Form

This information is needed for submitting claims and/or auditing purposes. Please fill in all areas.

Demographic Information:

Name:_____   Date:_____

Date of Birth:_____   Relationship Status:_____

                                          Gender:_____

Mailing Address:_____ City: _____State: _____Zip Code :_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____ Preferred method of Contact:_____

Current Employer:_____ Position Title:_____

Who referred you:_____

Payment Method:_____Cash Pay   _____Insurance   _____EAP

Name, Phone, & Relationship of a close relative/friend to alert in an emergency:

_____

Insurance Required Information

Insurance Company:_____Member ID:_____Group Number: _____

Customer Service Phone Number(on back of the card):_____

Subscriber Name:_____Subscriber Date of Birth:_____

Subscriber Relationship to Client:_____

Employer:_____

Authorization Number(if needed):_____

Copay:_____ Coinsurance:_____ Deductible_____

Do you have out-of-network benefits:_____

(This information is not a guarantee of coverage. We will not know your exact coverage until we receive an

explanation of benefits after billing the first session.)

Current Concerns (What brought you to counseling?, Severity of problem?, Impact of problem?):_____

_____

_____

_____

Goals (What do you hope to accomplish in counseling?)_____

_____

_____

HISTORY:

Have you been in counseling before? If so, when? _____

_____

Did you find this experience helpful? Why or why not? _____

_____

Are you under the care of a physician or psychiatrist? Please list names and phone numbers:_____

Have you ever been psychiatrically hospitalized? If so, when?_____

Are you currently on any medications? Please list:_____

Do you currently use drugs/alcohol? Please list how much and how often?_____

_____

Are you currently experiecning any legal difficulties?_____

Your signature will indicate that you understand and accept the information contained in the two-page document "Informed Consent Information", and that you have received a copy of the HIPPA Privacy Policy.

_____   _____
Client or Parent/Guardian Signature   **Date**

_____   _____
Witness Signature   **Date**

Co Pay / Session Fee: Due at the beginning of each appointment. (Cash, or Check, or CC)