Intake: Please complete this form fully and bring a list of current medications to attach.
Photo ID card of client or guardian(s) and insurance card will be copied for office records.

Client Name: ____ DOB:____/____/____

Parent/Guardian/Spouse (circle): ____

Parent/Guardian/Spouse (circle): ____

Reason for seeking counseling: ____

Address: ____ City: ______________________

State: _________________ Zip: ____________ School: ______________________________________

Home Phone: ___________ Cell Phone: _______________ Do you text? ☐ Yes ☐ No

Okay to leave a msg? ☐ Home ☐ Cell E-mail: ____

Marital Status: ________________________ Employer/school: __________________________________

Payment Method: ☐Insurance ☐Self Pay ☐ Other: ____

Credit Card for no-show: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Exp: _ _/_ _ Code __ ___ ___ Billing Zip ________

Primary Insurance:____________________________________ ID #: _____________________________

Group #:______________Subscriber Name: ___________________________Co-Pay: ________ Ded: ____

Insurance Subscriber's Address: ____

Insurance Phone for Mental Health:_______________________________ Subscriber DOB:____/____/____

Secondary Insurance: WE DO NOT BILL SECONDARY INSURANCES. YOU WILL BE RESPONSIBLE FOR BALANCES.

Authorization Number: ____________________________________ Dates Authorized: _________________

Emergency Contact Name: ____________________________________ ER Contact Relationship:__________

Emergency Contact Phone: ________________________________ Is a release on file for this person? Yes No

How were you referred?_____________________________ If online, which website?____________________

Primary Care Provider: ____ Fax: ____________________

For office use: Date and time of Initial phone call: __________________ Follow-up ____________________

For office use: Scheduled with: _______________________ Date/Time: ______________________________

☐Paperwork emailed

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