



**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: _____ Gender: _____ 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 Access to Computer? Yes No

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

Marital Status: _____ Employer/school: _____

Payment Method: Insurance Self Pay Other: _____

Required 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: _____

In person (bring mask) requested Teletherapy requested Scheduling requests: _____

For office use: Date and time of Initial phone call/email: _____ Follow-up _____

For office use: Scheduled with: _____ Date/Time: _____

Portal Access Emailed

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