Amber Sky Counseling Services

Intake Sheet **Please fill out SECTION 1 AND SECTION 2 BELOW:**

SECTION 1: Client information **PLEASE PRINT CLEARLY** **DATE: ____/____/____**

Client Name: _____ DOB _____/_____/_____ Age _____ Guardian (s): _____

Address: (# and Street) _____ (City) _____ (State) _____ (Zip Code) _____

Phone home: _____ cell: _____ E-Mail_____

(By entering an E-mail address you are agreeing to its use for the purpose of correspondence and invoice submission.)

(Circle One) Single, Married, Separated, Divorced (Circle One) Employed (Full time) (Part time) (No) (Retired)

(Circle One) Student (Full time) (Part time) (No) (Circle One) Gender M F

If a child Father's name_____ Mother's name_____

I, (Print) _____ give permission to individuals from Amber Sky Counseling to call

_____ in an Emergency. PHONE #_____

Relationship to Client_____ Sign _____

SECTION 2: Policy card holder's information

Name of Insurance Company: _____ Policy Holders Name_____ DOB____/____/____

Address (street) _____ (City) _____ (State) _____ (Zip code) _____

Phone Number_____ Relationship to client: _____ Subscriber's Employer: _____

Insurance # with all letters and numbers (from your card): _____ **HMO PPO OTHER** (Circle One)

Group #_____Co-pay: $_____ Deductible: $_____ Please note that co-payments and/or deductibles are due at every session.

I, (please sign) _____ understand that Amber Sky Counseling, will bill my insurance company with the information above and if this information is false or my insurance company does not allow this treatment I will be responsible for the cost of this treatment. The cost of therapy treatment sessions are $150.00 for diagnostic, $125.00 for Family and 100.00 for Individual follow up sessions.

Credit Card Information and authorization.

I hereby authorize Amber Sky Counseling to deduct from my credit card or debit account the fees due for service to include co-payments, co-insurance, missed sessions ($60 fee), and payments not received or covered by insurance. My Credit info is: CARD # __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ Exp. Date __ __ / __ __

Name on the card_____ Please sign here:_____

CURRENT DIAGNOSES based on this assessment:

AXIS I: _____ _____ _____ **AXIS II:** _____ _____

AXIS III: _____ **AXIS IV:** _____

AXIS V (GAF): _____