

The Counseling Shop

11224 86th Ave. N.
Maple Grove, MN 55369
Phone: (763) 400-7075

CLIENT INTAKE FORM

(Please Print)

Today's Date ____/____/____

CLIENT INFORMATION

Client's Last Name		First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Married / Other	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name? (Former Name)		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F		
Street Address		City	State	Zip Code	Home Phone No. ()		
P.O. Box	City	State	ZIP Code	Cell Phone No. ()			
Occupation	Employer			Work Phone No. ()			
Referred to Provider by (Please check one box & list) <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____				<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Website	
Email Address:				Alternative Email Address:			

INSURANCE INFORMATION

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ()
Email Address:			Cell Phone No. ()
Occupation	Employer	Employer Address	Work Phone No. ()
Is this client covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this an EAP visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Annual EAPs allowed? _____	
Please Select Your Primary Insurance Provider	<input type="checkbox"/> Health Partners <input type="checkbox"/> Medica <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Preferred One <input type="checkbox"/> America's PPO		
	<input type="checkbox"/> Cigna <input type="checkbox"/> Life Synch/ Humana <input type="checkbox"/> Aetna <input type="checkbox"/> Medicaid/MA <input type="checkbox"/> Medicare <input type="checkbox"/> PHCS		
<input type="checkbox"/> MN Care <input type="checkbox"/> U Care <input type="checkbox"/> United Healthcare <input type="checkbox"/> Value Options			
<input type="checkbox"/> Other _____			
What is the authorization number?			<input type="checkbox"/> Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
Client's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance (if any)		Insured's Name	Group #	Policy #	
Client's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

The Counseling Shop

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. The Counseling Shop will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____
CLIENT/GUARDIAN SIGNATURE DATE