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Client Intake Form

Client Information:

Client's Name: _____ Date of Birth: ___/___/___

M/F_____ Marital Status _____ Telephone: (___)_____

Physical Address: _____

Mailing Address (if different): _____

Client's Social Security #: ____-____-____

Employer: _____ Work Phone: (___)_____

Significant Other/Spouse's Name: _____Date of Birth: ___/___/___

Their Employer: _____ Work Phone: (___)_____

Your primary reason for being here: _____

How long has this been a concern? _____

What have you tried so far? _____

Is there any other information you think I may need to know? _____

_____

_____

Who can I thank for referring you? _____

Responsible Party/Guardian Information:

Responsible Party/Guardian (if different from above): _____

Date of Birth (of responsible party): ___/___/___ Relationship to client: _____

Responsible Party's Social Security #: ____-____-____

Employer: _____ Work Phone: (___)_____

Insurance Information:

Primary Insurance: _____

Name of Policy Holder: _____ Date of Birth: ___/___/___

Relationship to client: _____Subscriber ID#: _____

Group #: _____Customer Service Phone #: _____

Employer of Subscriber: _____

Secondary Insurance Information:

Secondary insurance: _____

Name of Policy Holder: _____ Date of Birth: ___/___/___

Relationship to client: _____Subscriber ID#: _____

Group #: _____Customer Service Phone #: _____

Employer of Subscriber: _____

Victim Witness:

Claim Number (required): _____

Do you have private insurance? _____ If so you must provide the above insurance information.

Name of Victim: _____Relationship to Victim: _____

Name of Advocate at Victim Witness: _____

Insurance Certification and Assignment: I hereby certify that the information given to me in applying for payment under the title XIX of the Social Security Act, by insurers, or by any other third party is correct. I assign payment to the provider rendering medical service to the client. I understand that I am responsible for payment of any health insurance deductible(s), co-insurance, or any other charges incurred which are not paid by any insurance of third party payers.

Release of Information: I hereby authorize my psychotherapist, physician, hospital, pharmacy, insurance company, employer or organization responsible for payment of this claim or to any physician or health service provider who will render care to the client after discharge:

I understand that all the charges incurred are my responsibility, regardless of insurance coverage or third party agency. For collection I agree to pay all reasonable court costs and collection fees. I understand that all judgments in a court of law may bear interest at the legal rate.

Client/Guardian/Responsible Party Signature: _____

Date: _____