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New Client Intake Form

Name: _____Date of Birth: _____

Physical Address: _____City: _____Zip Code: _____
Mailing Address (If Different): _____City: _____Zip Code: _____
Cell Phone: _____ May I leave a message Y N

Emergency Contact: _____
Phone #: _____Relationship: _____

Insurance Information:
Does Patient or Policy Holder have an Employee Assistance Program? _____
If so, Name of EAP: _____ EAP Phone #: _____
How many sessions? _____Authorization # _____

Other Insurance Information (Mental Health Benefit):
Insurance Name: _____Phone #: _____
Insurance ID#: _____Group #: _____
Authorization #: _____ How many sessions? _____
What is your Co-Pay? _____ Do you have a deductible? _____How Much? _____

Insurance Certification & Assignment:
I hereby certify that the information given to me in applying for payment by insurers or any other 3rd party is correct. I understand that I am responsible for payment of any health insurance deductible, co-insurance, or any other charges incurred, which are not paid by any insurance or 3rd party payers.

Release of Information: I authorize the release of any medical or other information necessary to process any insurance claims for services rendered.

Fee for Service Understanding: I understand that all the charges incurred are my responsibility, regardless of insurance coverage or 3rd 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.

Patient/Guardian Signature: _____Date: _____

Patient/Guardian Signature: _____Date: _____