

**Ann J. Burke, MA, LMFT License #40730
4030 Truxel Rd., Suite C-6
Sacramento, CA 95834 916-419-4457**

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: _____