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New Client Intake Form

Today's Date: _____ Referred by: _____

Name: _____ Date of Birth: _____

Physical Address: _____ City: _____ Zip Code: _____

Mailing Address (If Different): _____ City: _____ Zip Code: _____

Home Phone: _____ May I leave a message Y N

Cell Phone: _____ May I leave a message Y N

Responsible Party: _____ Date of Birth: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Treatment of Minor Child: Child's Name: _____

Parent or Legal Guardian Name: _____

School: _____ Grade: _____ Teacher: _____

Insurance Information:

Does Patient or Policy Holder have an Employee Assistance Program? _____ If so, Name of EAP: _____

EAP Phone #: _____ How many sessions have been approved? _____ 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: _____