ADULT INTAKE INFORMATION FOR COUNSELING SERVICES

Patient's Name: _____ Birth date: _____
Patient's Physical Address:_____
Billing/Mailing Address: _____Zip code: _____
Home Phone No.:_____ Other message number: _____
Preferred Contact Method: _____
Emergency Contact(s): _____
Patient's Social Sec. No.: _____
Employer (if employed): _____Position: _____
Work Phone: _____ Is it alright to contact at this number?_____
If Married Adult, Spouse's Name: _____Birth date: _____
Names & dates of birth of any children_____; _____
_____; _____;_____
Primary Care Physician: _____ Other Care Provider(s):_____
Date of last exam: _____
Any medical conditions: _____
_____
Medications:_____
_____
Any previous mental health treatment (please indicate dates service provider)? _____
_____
Referred by? _____
What brings you in for therapy at this time? _____
_____

Primary Insurance Carrier: _____Copay?_____EAP?___
Address:_____Phone_____
Subscriber name: _____Birth date: _____
Subscriber ID #: _____ Group #: _____
Authorization # (if applic.): _____ Number/dates auth: _____
Secondary Insurance Carrier: _____Copay? _____
Address: _____Phone: _____
Subscriber name: _____Birth date:_____
Subscriber ID #: _____ Group #: _____

Insurance Billing: I will bill your insurance for you unless you request that I not do so. Please sign below if you wish to authorize our office to process your claim which includes submitting your identifying information electronically to your insurance company with the dates of service, clinical diagnosis, and treatment modality. Your insurance company may also request copies of your counseling records. Unless otherwise indicated, benefits will be assigned to me for services rendered. It remains your responsibility to comply with the requirements of your plan including responding to their inquiries, calling for pre-authorization, notifying me in a timely manner of insurance changes, paying for copays, deductibles, and/or other balances not covered by your insurance plan. The fee for services is $90 per fifty minute counseling session or the rate allowed by your insurance if I am listed as a provider. A $5 discount per session is available if fees are paid in full at the time of service. You will receive a bill at the end of the month for any unpaid balance and payment is expected upon receipt. I agree to have your office bill my insurance:
Signature: _____ Date: _____

Or under HIPAA, I request that you NOT bill my insurance and I will pay out of pocket.
Signature: _____ Date:_____