CONFIDENTIAL CLIENT INTAKE

GENERAL INFORMATION

Name:____ Date:_____/_____/______

Social Security #: ________-_______-__________ Date of Birth:_____/_____/______

Address: ____

City: __________________________________ State: ______ Zip: _____________

Phone: (home)_____________________________ (cell)____________________________

Email: ____

May we call you at home? ❏ Yes ❏ No Okay to leave a message at home? ❏ Yes ❏ No

May we call your cell? ❏ Yes ❏ No Okay to leave a message on cell? ❏ Yes ❏ No

May we text your cell? ❏ Yes ❏ No Please list cell service provider (to text): ____________

May we email you? ❏ Yes ❏ No

Person to notify in the event of an emergency: _______________________________________

Emergency contact's relationship to you: _______________ Contact's phone: ________________

Whom may we thank for referring you? ____

EDUCATION & VOCATIONAL INFORMATION

Highest grade completed and/or degree(s) obtained: ____________________________________

Current Occupation:_____________________________ Employer: _____________________

Household annual income: ____

FAMILY INFORMATION

Present Relationship Status (check all that apply):

❏ Married/Partnered (yrs:___ mos:___)
❏ Single (yrs:___ mos:___)
❏ In a new relationship (6 mos or less)
❏ Dating: ❏ one person ❏ several persons
❏ Widow/Widower (yrs:___ mos:___)
❏ Other: ____________________

If married, partnered or in a primary relationship, do you live with your significant other? ❏ Yes ❏ No

Others living in your household:

Name	Relationship	Age

MEDICAL INFORMATION

Medical Doctor:_______________________________________ Phone: ____________________________

Date of last physical exam (approx) ____/_____/______

How would you rate your physical health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Psychiatrist:____ Phone: ____________________________

Other Specialist:______________________________________ Phone: ____________________________

List any medications you are currently taking (including non-prescription or herbal remedies): _______

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____

Describe any current physical problems or concerns that you have: ____________________________

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____

List any history of significant physical problems (e.g, broken bones, head injury, surgery): __________

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PAYMENT INFORMATION

Please provide credit/debit card information. Your credit/debit card will not be charged at this time, *please see note below for details*.

Credit Card #:____ Exp Date: _____________

Type: ❑ Visa ❑ MasterCard ❑ American Express CVV Code: _____________

Name on Card: ________________________________Bank Name: ____________________________

Billing Address (if different than above): ____

NOTE: In order to prevent any misunderstandings about use of insurance as payment of services, please be advised of the following: (1) All services provided are billed directly to the client unless other arrangements have been made; (2) Clients are personally responsible for payment at time of service via cash, check or money order; (3) Statements can be provided for you to submit for insurance reimbursement; (4) You are responsible for submitting all claims to your insurance provider; (5) If payment is not received when services are rendered, payment plus 5% will be applied to the credit card on file as detailed in the following agreement: I (client) authorize you to reserve credit with the card issued in an amount equal to all outstanding charges, plus a 5% fee. You may bill my card issuer at time of service if no other payment arrangements have been made. Payment Guarantee: I understand that I am individually responsible for all incurred charges, even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to bill charges to another person who fails to make payment promptly when due, I will promptly pay on demand. I understand there is a 24-hour cancellation policy for therapy sessions, and that I will be charged in the event that I fail to attend an appointment without providing 24 hours advance notice. If I commit to group therapy, I understand that the weekly fee for group sessions is due even if I do not attend.

I have read, understand and agree to the information and guidelines stated above.

____ ________________________

Signature Date