Intake Form

PLEASE COMPLETE THE FOLLOWING INFORMATION AND BRING THIS FORM WITH YOU TO YOUR FIRST SESSION.

Legal Name _____

Chosen and/or Preferred Names _____

Address _____

_____

Email Address _____

Phone Number _____
Is it okay to leave a confidential voice mail? *YES* ☐ *NO* ☐

Date of Birth _____ *Age* _____ *Social Security Number* _____

Occupation _____ *Employer* _____

Are you retired? Yes ☐ *No* ☐

If so, for how long? _____

What is the name of your primary insurance company? _____

Insurance Member ID/Policy Number _____

Group Number _____

Client's relationship to insurance subscriber: Self ☐ *Spouse* ☐ *Child* ☐ *Other* ☐

Subscriber's name (if different from above) _____

Subscriber's address (if different from above) _____

_____

Subscriber's birth date (if different from above) _____

Subscriber's social security number. (if different from above) _____

*Emergency Contact*_____

Relationship to Client _____ *Phone number*_____

What is your reason for coming to counseling? _____

_____

_____

The above information is true to the best of my knowledge. I authorize my insurance to be billed for services. I understand that I am financially responsible for any balance. I also authorize Amanda Lawson-Ross, Ph.D. or insurance company to release any information required to process my claims.

*SIGNATURE*_____

*DATE*_____