NEW CLIENT INTAKE FORM

Client Information:

Full Name:____Date:__________________________________

Address:____Date of Birth:__________________________

City/State/Zip:____

Home Phone:_________________________________Cell phone:______________________________________

Work Phone:__________________________________Email Address:__________________________________

Which phone number would you prefer to receive voice mail messages on? ______________________________

Social Security Number:__________________________________Marital Status:__________________________

Employer or School Name:____

Employer Address, City, State, Zip:____

Employed: ( ) Full time ( ) Part time Student: ( ) Full time ( ) Part time

Occupation:____________________________________Education:____________________________________

Party Responsible for Payment: (if different from above please fill out entirely)

Name:____Date of Birth:___________________________________

Address:____________________________________City/State/Zip:___________________________________

Home Phone:______________________________Cell Phone:____

Work Phone:____________________________________Marital Status:________________________________

Social Security Number:____

Employer or School Name:____

Employer Address, City, State, Zip:____

Insurance:

Name, birth date and social security number of insured:

____

____

Insurance Company:_______________________________________Telephone Number:_____________________

Group and other insurance ID numbers:____

Medical Information:

Health Problems:____

Physician Name and Phone Number:____

Current Medications and Dosage:____

Please read and sign the following agreement. Do not sign it unless it is clear to you.

I have reviewed the Psychotherapist-Client Services Agreement and the Notice of Privacy Practices. I understand my and Mind Body Connection, LLC's rights and responsibilities, and agree to be bound by those documents. I understand that my therapist may, and give permission for my therapist to, discuss my case with other therapists at Mind Body Connections, LLC and within the Clarus Center community for supervisory purposes and collaborative treatment as indicated by my therapist's judgment. I give Mind Body Connections, LLC permission to bill my insurance company for services. I understand that I am responsible for paying my fee, regardless of whether my insurance covers it.

Signed:____Date:________________________

Witness:____Date:________________________

I authorize Mind Body Connections, LLC to charge my credit card (Visa, Discover or Master Card) for any balances overdue by 90 days.

______________________________ ______________________________ ______________

Signature Credit Card Number Exp. Date

●●

Office Use Only below this line

Diagnosis Code: Session Fee:

Pre-certification and verification of benefits:

Deductible: % paid by insurance: Maximum fee:

Yearly Maximum: Lifetime maximum: Marital covered?

How to bill?

Billing address____

If client has BCBS insurance: Date of current Illness/injury:______________________________

Same/Similar Illness-first date:______________________________

Billing Instructions:

☐File with insurance company ☐Request insurance company to reimburse client directly

☐Client will handle insurance if any ☐ Send monthly bill to client ☐ Do not bill client