Associates In Mental Health
Administrative Office: (360) 715-2488

INTAKE SHEET

Date: _____ Form completed by: [ ] self [ ] parent [ ] guardian [ ] spouse

Client Name: _____ Referred by _____

Date of birth: _____ Primary Care Physician _____

Social Security Number _____

Street Address _____

City _____ Zip _____

Phone: Home _____ [ ] Work _____ [ ] Cell _____
[Check box if NOT okay to call/leave message]

Marital Status: [ ] single [ ] married [ ] divorced [ ] widowed [ ] other _____

Education: highest grade completed_____ degree _____

Employer:_____ Occupation: _____

[ ] full-time [ ] part-time [ ] retired

Emergency Contact:

Name: _____

Relationship to client: _____

Phone: Home _____ Work _____ Cell _____

If client is a student:
Grade: _____

School: _____

Teacher(s)_____

School Counselor _____

Please list any other persons residing in home

Name	Age	Relationship to client

If client is a minor, please list any Parent(s) or sibling(s) not residing with client

Name	Age	Relationship to client

Therapist Use Only: DSM-IV _____

- Please complete other side -

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INSURANCE/BILLING INFORMATION

Client Name _____

Person responsible for copayments, coinsurance, deductibles, and/or payment in full:

Name: _____ Relationship to client: _____

Social Security Number _____ Date of Birth _____

Phone Number _____ Employer _____

Address (if different than client's) _____

Please provide insurance card(s) at first appointment

PRIMARY INSURANCE COMPANY _____ _____

Subscriber's Name _____ Date of Birth _____

Social Security Number _____ Employer_____

Address (if different than client's) _____

SECONDARY INSURANCE COMPANY _____

Subscriber's Name _____ Date of Birth _____

Social Security Number _____ Employer_____

Address (if different than client's) _____

Payment and Insurance billing:

I, the undersigned, authorize the release of any medical or other information necessary to process this claim through any insurance company previously noted. I authorize payment to the providing clinician for services rendered as stated on claims submitted by him/her to my insurance company.

I also understand that it is my responsibility to reimburse my therapist for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered or I do not have insurance coverage at this time, I agree to pay any and all costs of counseling. Costs may include any missed appointments, fees for written reports, phone calls on my behalf, or any other costs of providing services on my behalf.

Client or Authorized Person's Signature: _____
Relationship to Client: _____

For your information, your insurance company may require your therapist to exchange information with your referring and/or primary care physician. They may also require your therapist to provide copies of confidential chart notes in order to process your claim(s). You have the right to notify your therapist in writing to limit communication with your physician(s). You may also make arrangements to pay for therapy privately to avoid confidential information being released to your insurance company. Please discuss these options with your therapist.