Associates In Mental Health Administrative Office *(360) 715 - 2488 Phone*
1116 Key St Ste 204 Bellingham, WA 98225 *(360) 671 - 1842 Fax*

INTAKE FORM

Client Name: _____ **Date**:_____/_____/_____

Referred By: _____ **Form Completed By**: [ ] self [ ] parent [ ] guardian [ ] spouse/equivalent

Date of Birth: _____/_____/_____ **Primary Care Physician**:_____

Street Address: _____

City/State/Zip: _____

Phone: Okay to call/leave message? Please note with a "Y" or an "N" for (Y)es or (N)o.
[ ] Cell:_____ [ ] Home:_____ [ ] Work:_____[ ]

Education: highest grade completed: _____degree(s): _____
Employer: _____ **Occupation**:_____
[ ] full-time [ ] part-time [ ] retired

Relational Status: [ ] single [ ] married [ ] partnered [ ] divorced [ ] widowed [ ] other

Emergency Contact: _____ Relationship to client: _____
Phone: [ ] cell:_____ [ ] home:_____ [ ] work :_____

Please list other persons/family members residing in home

Name	Age	Relationship to Client

If client is a minor please list any parent(s) or sibling(s) not residing in the home

Name	Age	Relationship to Client

Therapist Use Only, DSM-5: _____

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INSURANCE/BILLING INFORMATION

Client Name: _____

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

Relationship to Client: _____ **Date of Birth**: _____/_____/_____
Phone: [ ] cell:_____ [ ] home:_____ [ ] work: _____
Employer: _____
Address (if different than client's):
Street:_____**City/State/Zip**:_____

Please provide insurance card(s) at first appointment

PRIMARY INSURANCE COMPANY:
_____
Subscriber's Name: _____ Date of Birth: _____/_____/_____
Employer: _____
Address (if different than client's):
Street:_____City/State/Zip:_____

SECONDARY INSURANCECOMPANY:
_____
Subscriber's Name: _____ Date of Birth:_____/_____/_____
Employer: _____
Address (if different than client's):
Street:_____City/State/Zip:_____

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.