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

INTAKE SHEET

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

Client Name: _____

Personal Pronoun [optional] _____ Referred by _____

Street Address _____

City _____ Zip _____

Can we leave you a phone message? Circle Yes or No

Phone: Home _____ Cell _____ Work _____

Yes No Yes No Yes No

Date of Birth: _____ Age _____ Social Security Number _____

Primary Care Physician _____

Marital Status: [ ] single [ ] married [ ] partnered [ ] divorced [ ] widowed

Education: highest grade completed_____ degree _____

Employer: _____ Occupation: _____

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

Person responsible for copayments, coinsurance, deductibles, and/or payment in full:
(if different than client's)

Name: _____ Relationship to client: _____

Address _____ Phone _____

Social Security Number _____ Date of Birth _____

Please provide Insurance card(s) at first appointment.

PRIMARY INSURANCE COMPANY _____

Member's #ID: _____ Date of Birth _____

Subscriber's Name _____ Social Security _____
(if different than client's)
Subscriber's Address _____ Employer _____

SECONDARY INSURANCE COMPANY _____

Member's #ID: _____ Date of Birth _____
Subscriber's Name _____ Social Security _____
(if different than client's)
Subscriber's Address _____ Employer _____

Therapist Use Only: ICD-10: _____ **Date Submitted**: _____

Provider Initials _____

- Please complete other side -

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Client Name: _____

Emergency Contact:

Name: _____ Relationship to client: _____

Phone: Home _____ Work _____ Cell _____

If client is a student:

Grade: _____ School: _____

School Counselor _____ Teacher(s)_____

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

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.