rev. 05.29.19

LifeWorks Counseling Center, LLC, Intake

Date: _____________ Referral Source: ____________________________ Info Taken By:_______

Client Name: ________________________________ **Date of Birth:** ______________________

Emergency Contact (name, relationship, phone #): _______________________________________

If the client is 13 years of age or younger, you must ask the following:

Are you the biological parent? □ Yes □ No (Only a biological parent may call for treatment).

Mother's name: __________________________ Father's name: __________________________________

Are both the biological mother and the biological father in the household? □ Yes □ No (If "No," the other biological parent MUST give written consent for treatment for clients age 13 and younger).

Are you married to each other? □ Yes □ No If no, does the biological parent have sole legal custody? If yes, the court paperwork MUST be brought to the initial appointment. If no, the other biological parent MUST give written consent for treatment for clients age 13 and younger.

Address: ____

Home phone: __________________ Cell: _________________ Email: ______________________________

Work: _______________ **OK FOR MSG**(check if yes): home ____ cell: ____ email: ____ work:_____

Male _____ Female ____ Marital Status _____ Employer or School: _________________________________

Currently in treatment with another therapist/psychiatrist/facility? □ No □ Yes (Name _________________)

Insurance Information:

PRIMARY Insurance Co: ____________________________________ Phone: _______________________

Policy Holder's Name: ________________________________ Policy Holder's DOB: ______________________

Policy holder's social security number (required by insurance) ___________________________________

ID#: ____________________ Group#:_____________________ Name of Employer: ___________________

Rel. to Client __________ Copay _________ Deductible/Other _____________________________________

Name and information of person accepting financial responsibility for account (if other than client):

Name: ____ DOB: ___________________________

Address: ____ Phone: __________________________

PLEASE NOTE: The person accepting financial responsibility for the account must sign the Authorization for Treatment & Payment of Medical Benefits, Fee Schedule, and Client Financial Responsibility Form.

SECONDARY Insurance or **EAP** name: ___________________________ Phone: ________________________

Policy Holder's Name: _________________________________ Policy Holder's DOB: ____________________

ID#: _____________________ Group#:__________________ Relationship to Client: ___________________

Copay ____________ Deductible _____________________ # Sessions per cal year __________________

Appointment Information: Availability ____

Reason for visit:

____

Initial Request: Individual Couple Parent/Child Family