NEW CLIENT/INSURANCE INTAKE

(PLEASE FILL OUT TOP PORTION ONLY)

Name: _____ Date: _____ Therapist: _____

Address: _____ City/State: _____ Zip: _____

DOB: _____ Sex: _____ Phone: _____

Insured Name: _____ Relationship to Client: self spouse parent other _____

Insured DOB: _____ Address/City/Zip: _____

Appointment Date: _____ Time: _____

OFFICE USE ONLY

Insurance Company Name: _____ Phone #: _____

Member ID #: _____ Authorization #: _____

Deductible: _____ Amount Met: _____

CoPay Amount Due: _____ Diagnosis: _____

Total # Sessions: _____ Begin/End: _____

I am signing below to acknowledge that I understand that my above mentioned insurance will be billed for any and all sessions with my therapist and/or any associates in this office.

Sign:_____ Date:_____

Session #	***Date of Session***	***Amount Due***	***Amount Paid***