Confidential Client Intake Information Form

SEASONS THERAPY

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General Information:

Client Last Name: _____ First Name: _____ M.I.___
Social Security Number: _____ Date of Birth: _____
Street Address: _____ Apt. #:_____
City: _____ State: _____ Zip: _____
Hm #: (_____)_____ Wk #: (_____)_____
Cell #: (_____)_____ Email: _____
Guardian/Parent (If under 18): _____
How did you learn of Seasons Therapy/ Referred by:_____

Insurance Information **Please write clearly and complete all information**

Primary Insurance: _____ Policy Holder: _____
Date of Birth: _____ I. D. # _____
Phone # on Card: _____
Address on Card for Claims:_____

Secondary Insurance: _____ Policy Holder: _____
Date of Birth: _____ I. D. # _____
Phone # on Card: _____
Address on Card for Claims:_____

All fees are due at time of service.

Insurance Benefits:

DX: _____Deductible: _____ Copay:_____
Co-Insurance: _____ Auth: _____
sessions per Auth: _____ Auth valid from ____-____-____ to ____-____-____
Max per calendar year: Codes:

SELF PAY: Gross Family Income: _____

PRESENTING PROBLEM:

Are any of the following a problem for you at this time? **Mark all that apply.**

___Anxiety	___Grief	___Depression	___Loss of Hope
___Loneliness	___Loss of Faith	___Substance Abuse	___ Stress
___Chronic Fears	___Sleep problems	___Suicidal Thoughts	___Anger
___Partner Problems	___Self Esteem	___Rage	___ Sexual Problems
___Guilt Feelings	___Family Problems	___Work Problems	

___Other _____

___ Do you have thoughts of harming yourself or others?
___ Are thoughts of harming yourself or others a frequent occurrence?
___ Do you dwell on these thoughts and wonder if you can control them?
___ Have you sought professional help because of these thoughts or feelings?

MEDICAL/PSYCHOLOGICAL HISTORY:

Name and phone # of your physician: _____
Are you suffering from any medical illness at this time and if so, what? _____
_____
List any major illnesses or surgeries in the last 5 years: _____
_____
List current medications: _____
_____
Have you received help/counseling in the past? _____ When: _____
Name of Therapist: _____
Type of problem: _____

Acknowledgement: The information in this document is accurate to the best of my knowledge. I attest that I understand my signature below denotes consent for treatment, and that I have received both the HIPPA confidentiality form, and my counselor's professional disclosure statement. If requesting third party reimbursement, my signature allows Seasons Therapy to process an invoice for services provided and to release medical information to substantiate the claim. We will file your primary policy as a courtesy to you; your signature below acknowledges your responsibility if any balance remains after 90 days of nonpayment and/or the service is not covered for any reason. It is your responsibility to know and understand your insurance benefits, including any and all copays, co-insurance and deductibles.

Please be aware that we ask for a 24 hour notice if an appointment cannot be kept. A full charge will be billed if a session is missed. A $20 returned check fee will be assessed for all checks that are returned for non-sufficient funds.

_____ _____
Signature of Guarantor Date

_____ _____
Signature of Therapist Date