

icChoice.com

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CLIENT INTAKE FORM

(Please Print)

Today's Date / /

Therapist

CLIENT INFORMATION

Client's Last Name First Middle Mr. Ms. Marital Status (Circle One) Single / Married / Other

Is this your legal name? If not, what is your legal name? (Former Name) Birth Date Age Sex M F

Street Address City State ZIP Code Social Security Home Phone No.

P.O. Box City State ZIP Code Cell Phone No.

Occupation Employer Work Phone No.

Referred to Provider by (Please check one box & list) Dr. Insurance Plan Website Family Friend Close to Home/Work Yellow Pages Other

Email Address: Alternative Email Address:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill Birth Date Address (if different) Home Phone No.

Email Address: Cell Phone No.

Occupation Employer Employer Address Work Phone No.

Is this client covered by insurance? Yes No Is this an EAP visit? Yes No Total Annual EAPs allowed?

Please Select Your Primary Insurance Provider Amerigroup Assurant Beech Street Blue Cross/Blue Sheild ChoiceCare Champus Cigna Definity Health First Health HealthSmart Humana Magellan/Aetna Medicaid Medicare MHN/MHNet PHCS PMHS Texas One Choice TriCare Unicare United Healthcare Value Options Other

What is the authorization number? Self Pay

Insured's Name Insured's S.S. # Birth Date Group # Policy # Co-Payment \$

Client's Relationship to Insured Self Spouse Child Other

Name of Secondary Insurance (if any) annanaplicable Insured's Name Group # Policy #

Client's Relationship to Insured Self Spouse Child Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address) Relationship to Client Home Phone No. Work Phone No.

CLIENT INTAKE FORM
(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. _____ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____
CLIENT/GUARDIAN SIGNATURE DATE