

CLIENT INTAKE FORM

Referred By: _____

CLIENT INFORMATION

First MI
Last
Address

City ST Zip
Marital Single Married Widowed
 Divorced Separated

Home Cell
Work Email
Birth Date / /
Sex M F
Soc. #
Employ Employed Student
 Part Time Full Time

RESPONSIBLE PARTY INFORMATION (if other than client)

Name
Address

City ST Zip

Home Cell
Work Email
Sex M F
Other
Relation

If there are two responsible parties, fill out ANOTHER Intake Form and write "Second Responsible Party" on top of form

INSURANCE COMPANY INFORMATION - attach a copy (front & back) of insurance card

Ins. Co.
Address

City ST Zip

ID # Cell
Policy # Email
Group # Web
Phone Other

Policy Holder Information

First MI
Last
Address

City ST Zip
Employer

Birth Date / /
Soc. #
Sex M F
Home Cell
Work Email
Other

Are you under your employer's Health Plan? Yes No

What is your relationship to the insured? Spouse Child Self Other _____

Status (for Champus Claims) Active Retired Deceased Other _____

I authorize Deborah Squires Goeble, LISW-S, to release the information necessary to my insurance company for the purpose of billing for services rendered. I also understand that the remaining balance after insurance payment is my responsibility (including copays, deductible, and non-covered services). I authorize payments of my medical benefits to Deborah Squires Goeble, LISW-S.

Signature _____

Date _____

I have received and reviewed a copy of the Notice of Privacy Practices

Signature _____

Date _____