Cultivating Hope Counseling Services, PLLC
Intake Information

***__**This Sheet Must be Filled in Completely** (Please Print Clearly)__

Readmit: ___ Yes ___ No
Date_____ Client's Social Security # _____ Case # _____
Client's First Name _____ Last Name _____ MI _____
Address _____ City _____ State_____ Zip _____
Telephone (Home) _____ (Work) _____
Birthdate _____/_____/_____ Age _____ Gender _____F _____M Race_____
Name of Spouse/Guardian _____ Phone _____
Address _____ City _____ State _____ Zip _____

Person Responsible for Payment _____
Soc. Sec. # _____
Signature of Person Responsible for Payment _____
(Must be signed for services to begin)

__EMERGENCY INFORMATION__

In case of medical or psychiatric emergency, I give permission for Cultivating Hope Counseling Services, PLLC to contact and discuss my situation with the following individuals:

Name (1) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____
Name (2) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____

Signature _____

Physician _____ Phone _____
Address _____ City _____ State _____ Zip _____
Psychiatrist _____ Phone _____
Address _____ City _____ State _____ Zip _____
Other Physicians _____ Phone _____
Current Medications _____
Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs _____
Spouse: Place _____ Phone _____ Hrs _____

__INSURANCE INFORMATION__

Primary Insurance _____	Secondary Insurance _____
Phone_____	Phone_____
Contract/ID# _____	Contract/ID# _____
Group/Acct#_____	Group/Acct# _____
Subscriber_____	Subscriber _____
Subscriber Date of Birth_____	Subscriber Date of Birth_____
Client's relationship to Subscriber ___Self ___Spouse ___Child___Other_____	Client's relationship to Subscriber ___Self ___Spouse ___Child ____Other_____

PROVISIONS: Client pays $_____ Deductible amount Amount satisfied: $_____
Insurance pays_____ % for visits____–____ and_____ % for visits____–____
Type(s) of providers covered: _____ Supervision: _____
Prior authorization needed: _____
Effective date: _____ Policy anniversary: _____
Coverage for testing: _____ Annual limit: _____

__REFERRAL SOURCE__

How did you hear of our clinic (or from whom)? _____
Address _____ City _____ State _____ Zip _____
Phone _____ Relationship to referral source _____