A S R
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ADULT INTAKE INFORMATION FORM

Clent's Name _____DOB:_____M___F___

Address: _____ Permission to mail/email: Y__N__

City/Zip: _____ Permission to call/text: Y__N__

Phone:_____

Email: _____

Employer: _____ Referral Source: _____

Briefly describe the reason(s) for seeking help:

_____

_____

Name of Health Insurance:_____ ID#:_____

Group # / Name: _____Primary SSN_____

Primary insured's Name: _____ DOB:_____M___F___

Authorization #: _____ Co-Pay: _____

Primary Care Physician's Name/Date of last Appt.: _____

Allergies: _____Medical Problems: _____

Medications: _____

By signing below, I authorize the release of any medical (PHI) or other information necessary to process an insurance claim. I attest that my therapist will do all that is necessary to file insurance benefits on my behalf, and I authorize payment of medical benefits to my therapist directly. However, as the insured, I am responsible for paying any co-pays due on the date of service. I am also ultimately responsible for any denied claims that were properly filed in a timely manner.

_____ _____

Authorized Signature Date