

Journeys Counseling
2254 Flint Hill Drive, Suite 2
Dubuque, IA 52003
Phone: (413) 628-1083

CLIENT INTAKE FORM

(Please Print)

Today's Date ____/____/____

Therapist _____

CLIENT INFORMATION

Client's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Married / Other	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name? (Former Name)		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> 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) <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work				<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Website
				<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this an EAP visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		Total Annual EAPs allowed? _____	
Please Select Your Primary Insurance Provider		<input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> Aetna <input type="checkbox"/> SISCO <input type="checkbox"/> Midland's Choice <input type="checkbox"/> AmeriHealth <input type="checkbox"/> Amerigroup <input type="checkbox"/> United Healthcare <input type="checkbox"/> Other _____			

What is the authorization number? _____ Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
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Client's Relationship to Insured Self Spouse Child Other _____

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #
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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 Name: _____ DOB: ____/____/____

Journeys Counseling
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

Client Name: _____ DOB: ____/____/____