Journey…..*counseling and consultation*

Client Intake Information

Date: _____

Client Name: _____ DOB: __/__/__ SSN: ____-___-_____

Address: _____ Home phone: _____

_____ Work phone: _____

_____ Cell phone: _____

Occupation: _____ e-mail: _____

Employer: _____

Emergency Contact Person: _____ Relationship: _____

(how to best reach contact person) : _____

[Please attach copy of primary, as well as any secondary, insurance provider]

How did you find out about ***Journey Counseling and Consultation?***
___ Friend ___ Relative ___ Phone Book ___ another service provider
___ Website ___ Clergy ___ Other: _____

Consent for Care / Assignment of Benefits

I approve of these services. I certify that the above noted insurance carriers or payment sources are complete and correct as indicated (attached). I authorize the holder of medical or other information about me to release that information to third party payers as needed for this or related claims. I request that payment of authorized benefits be made to the provider on my behalf. I understand that the patient or I, as the responsible party, may be liable for services not covered by above (attached) noted insurance carriers.

Authorized Signature: _____ Date: _____