THE COUNSELING COLLABORATIVE

Dawn Nuding, LCPC, ATR

Intake Information

Client Name:_____ Date: _____
First/Last/Middle Initial

Please call me: _____ Pronouns: _____(he/she/them, etc)

Date of Birth: _____ Current Age: ____ Marital/Relationship Status: _____
mm/dd/yyyy

If under 18, Parent/Guardian Name: _____

Mailing Address:_____
_____

Physical Address (if different from above): _____
_____

Home Phone: _____ Cell Phone (client): _____

Work Number: _____ Cell Phone Parent/Guardian (if applicable): _____

Email: _____

Permission to text and email client ___ Yes ___No Signature: _____ Date: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____
Current Family Members (names, relations & ages):
_____
_____

Major Medical Conditions/Allergies:
_____
_____

Current Medications _____
_____

Medications Prescribed by: _____

Primary Care Physician: _____ Phone #: _____

Referred By (including self): _____

Briefly, what do you hope to gain from counseling?
_____
_____

Prior mental health treatment & mental health hospitalizations (providers & dates):
_____

Prior Diagnosis if known: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Seasonal ☐Student

PLAN FOR PAYMENT:

☐ Self-Pay ☐ School Contract ☐ Please bill my insurance (Insurance companies will be billed directly. It is the client's responsibility to check with all other insurance providers about out of network coverage. Co-pays and out of pocket payments are required at the time of service. Clients are responsible for payment if their insurance company does not pay.)

INSURANCE INFORMATION:

Relationship to insured (policy holder) : ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Co-Pay Amount: $_____

COMPLETE IF RELATIONSHIP TO INSURED IS OTHER THAN "SELF":

Name of Insured (policy holder): _____
First/Last/Middle Initial

Address of Insured: _____
Street/PO Box Town, State, Zip

Phone # of Insured: _____ DOB of Insured: _____

Social Security # of Insured: _____

Employer of Insured: _____

Insurance Company: _____

Insurance Company Phone #: _____

Insured's ID#: _____ Group #: _____

Plan: _____

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS:

I authorize the release of only necessary medical or other information required to process insurance claims. I also authorize payment of medical benefits to provider for services performed:

Client Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____