CLIENT INTAKE FORM (Please Print)

Today's Date: _____/_____/_____ **Doctor: MARK A. SCHNOSE, PH.D.**

CLIENT INFORMATION

Client's Last Name | First | Middle | ❑ Mr. ❑ Ms. | Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former Name) | Birth Date / / | Age | Sex ❑ M ❑ 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) ❑ Dr. ________ ❑ Insurance Plan ❑ Website

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ________

INSURANCE INFORMATION (PLEASE GIVE YOUR ID AND NSURANCE CARD TO THE CLINICIAN)

Person Responsible for Bill | Birth Date / / | Address (if different) | Home Phone No. ( )

Occupation | Cell Phone No. ( )

Employer | Employer Address | Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No | Is this an Employee Assistance Program visit? ❑ Yes ❑ No | Name of EAP: ________

Insurance Company Phone Number: ( ) | Phone No. of EAP: ( ) | Total Annual EAPs allowed? ________

Please Select Your Primary Insurance Company

❑ Aetna/Humana ❑ Anthem ❑ Blue Shield CA ❑ Blue Cross/Blue Shield National

❑ Beacon Health/CHIPA ❑ CIGNA ❑ Holman ❑ Magellan ❑ Medicare

❑ Managed Health Network/HealthNet ❑ Tricare ❑ Optum/United Behavioral Health

❑ Value (Beacon) Options ❑ Other ________________________________

What is the authorization number? | ❑ Self Pay

Insured's Name | Insured's S.S. # | Birth Date / / | Group # | Policy # | Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other ________

Name of Secondary Insurance (if any) | Insured's Name | Group # | Policy #

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.

(Please complete the other side of this page.)

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

- 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.

- I understand that I am responsible for my fee payment at the beginning of each appointment.

- I understand that all appointments not cancelled 24 hours prior to the session will be billed to the client.

- I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be obtained. Your therapist will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

- I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

- I authorize the payment of medical benefits to the provider of services.

X ____

CLIENT/GUARDIAN SIGNATURE DATE