Deb Thompson Counseling

Debthompsoncounseling.com
(605) 331-6359

Client Intake Form

Legal Name_____ Date_____
Date of Birth_____/____/____
Phone # cell_____ Home #_____
Work #_____ Other #_____
Is it ok to leave messages? Yes_____ No_____
Is it ok to text? Yes____ No_____
Address_____
_____Zip code_____
Email_____
Would you like email appointment reminders? Yes_____No_____
Place of Employment_____Occupation_____

Emergency Contact_____Phone #_____
Referral Source_____

INSURANCE INFORMATION (please present insurance card to make a copy)
Name of Insurance Company_____
Primary Insured's Name (if other than client)_____
Address of Primary Insured_____
Relationship to client (Self, Spouse, Child)_____
Primary Insured's Date of Birth_____

Member ID_____Group #_____
Plan Name_____

INSURANCE AUTHORIZATION I hereby authorize Deb Thompson Counseling to release necessary information to insurance carriers concerning my diagnosis and treatment in order to process my claims. I hereby authorize direct payment to Deb Thompson Counseling from insurance carriers for services rendered if my account is not paid in full. I permit a copy of this authorization to be used in place of the original.

Signature of Client (or Guardian) _____ Date _____