INTAKE SHEET

Sandra Hall, LMHC, CAP Dx Code: ___________
NPI: 1881638807 Referral Source: ___________

Client's Name: ____ _________ _______
Last First Middle
Address: _______________________________________ _________________ ______ _______
Street #, Name and Apt # City State Zip

Birthdate: _____/_____/_____ SSN# _____/_____/_____ Hm Phone ( ) ____________

Employer: _______________________________________ Wk Phone ( ) ____________
Cel Phone ( ) ____________
Marital Status ____ Married ____Divorced ____ Single Gender: ___ Male ___ Female

Name of Person Carries Ins. ____
Last First Middle
Address: _______________________________________ _________________ ______ _______
Street #, Name and Apt # City State Zip

Home/Cell: ( ) __________________ Relationship to client: _________________

SSN: _____/_____/_____ Birthdate: _____/_____/_____ Employer __________________

Primary Ins Co Name: ____________________________ ID Number _________ _________ _____

Name of Responsible Party: ____
Last Firs Middle
Address: _______________________________________ _________________ ______ _______
Street #, Name and Apt # City State Zip

Home/Cell: ( ) __________________ Relationship to client: _________________

SSN: _____/_____/_____ Birthdate: _____/_____/_____ Employer __________________

Emergency Contact: ____ ( ) _____________
Name & Address Phone #

Relationship to Client: ____
I give permission for my therapist to collect monies from and communicate directly with my insurance company: ________________________ _________________
Signed Dated

Client's Physician's Name: ____________________________ Phone ( ) _________________

Responsible Party: I understand that I am financially responsible for payment of all charges made during course of treat-ment and agree to pay as treatrment progresses. Should I default on payment, I understand that my balance is subject to collections and am also responsible for the collection fees which will be an additional 43% of the amount due.
(Medicaid members are exempt from this financial responsibility).

Signed: _______________________________ Date: ____________________