Associates in Mental Health
Administrative Office: (360) 715-2488

INTAKE SHEET

Date: ____________ Form completed by: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Spouse

Client Name: ____________ Personal Pronouns: ____________

Street Address: ____________ City: ____________ Zipcode: ____________

Phone Number: Home: ____________ Cell: ____________ Work: ____________

Can we leave a message? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Date of Birth: ____________ Age: ____________ Social Security Number: ____________

Primary Care Physician: ____________

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Education: Highest Level Completed: ____________ Degree: ____________

Employer: ____________ Occupation: ____________

☐ Full-time ☐ Part-time ☐ Retired

Person responsible for copayments, coinsurance, deductibles, and/or payment in full (if different than client):

Name: ____________ Relationship to client: ____________

Address (if different from client): ____________ Phone Number: ____________

Social Security Number: ____________ Date of Birth: ____________

****Please provide insurance card(s) at first appointment****

PRIMARY INSURANCE COMPANY: ____________

Member ID: ____________ Date of Birth: ____________

Subscriber's Name: ____________ Social Security Number: ____________

Subscriber's Address: ____________ Employer: ____________

SECONDARY INSURANCE COMPANY: ____________

Member ID: ____________ Date of Birth: ____________

Subscriber's Name: ____________ Social Security Number: ____________

Subscriber's Address: ____________ Employer: ____________

Therapist Use Only: ICD-10: ____________ Provider Initials: ____________ Date Submitted: ____________

Client Name: ____________________

Emergency Contact:

Name: ____________________ Relationship to Client: ____________________

Phone Number: Home: ____________ Cell: ____________ Work: ____________

Can we leave a message? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

If client is a student:

School: ____________________ Grade: ____________

School Counselor: ____________________ Teacher(s): ____________________

Please list anyone residing in-home with the client

Name	Age	Relationship to Client

If client is a minor, please list any parent(s) and/or sibling(s) not residing in the home

Name	Age	Relationship to Client

Payment and Insurance billing:

I, the undersigned, authorize the release of any medical or other information necessary to process this claim through any insurance company previously noted. I authorize payment to the providing clinician for services rendered as stated on claims submitted by him/her to my insurance company. I also understand that it is my responsibility to reimburse my therapist for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered or I do not have insurance coverage at this time, I agree to pay any and all costs of counseling. Costs may include any missed appointments, fees for written reports, phone calls on my behalf, or any other costs of providing services on my behalf.

Client or Authorized Person's Signature: ____________________

Relationship to Client: ____________________

For your information, your insurance company may require your therapist to exchange information with your referring and/or primary care physician. They may also require your therapist to provide copies of confidential chart notes in order to process your claim(s). You have the right to notify your therapist in writing to limit communication with your physician(s). You may also make arrangements to pay for therapy privately, to avoid confidential information being released to your insurance company. Please discuss these options with your therapist.