PSYCHOTHERAPEUTIC RESOURCES

ADMINISTRATIVE INTAKE FORM

_______________________________________ _____ __________ __________ ________________

Last Name First Name MI Age DOB Male/Female Social Security #

Street Address: ______________________________________ Phone #: Home: _______________________

Cell: _______________________

____ Work: _______________________

City State Zip Code

Spouse/Significant Other: ____

In case of emergency contact: Name: ________________________________ Phone #:__________________

Primary Insurance Company: _______________________________________ Effective Date: _______________

(If policyholder is different than client information above):

____ _________________________

First Name MI Last Name Social Security #

Address: ____ **DOB**: _________________________

Relationship to Client: ________________________ Employer: _______________________________________

Secondary Insurance Company: ____________________________________Effective Date: _________________

(If policyholder is different than client information above):

____ _________________________

First Name MI Last Name Social Security #

Address: ____ **DOB**: __________________________

Relationship to Client: ________________________ Employer: ____

***It is your responsibility to inform PR of changes in address, phone #, and insurance coverage.**

We may need to communicate with you by phone **(Note: Our clinic name and phone number will show up on caller I.D. if we call you.) Do you have an objection or special request**? **YES**_______________NO_____________*

If **YES,** you will need to complete a **REQUEST FOR CONFIDENTIAL HANDLING OF HEALTH INFORMATION**

_____ **Please initial** to acknowledge that you have read and consented to the billing terms and conditions which include:

1. Terms of Billing
2. Release of health information as needed for collection purposes
3. Medical benefit assignment

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Important policies are viewable on our website. (www.yourcaringresource.com) by clicking Policies. Please read our **Notice of Privacy Practices, and Bill Of Rights of Clients**. Would you like a hard copy? YES____ NO____

I have received "Welcome to Psychotherapeutics Resource. Yes____

____ __________________

Signature **Date**

****If you have left anything blank, we will assume the answer is NO.**