Intake Date_____
Therapist_____
First Appt_____
Time_____

# Bottom Line
# Counseling Ministry
# Initial Contact Form
# Confidential

Assigned _____
Direct Referral _____
Appt. Kept _____
D/L & Ins Card _____

Patient _____ D O B ____/____/_____ Phone _____

Address _____ City _____ State _____ Zip _____

Initial presenting issue _____

_____

_____

_____

Referral source _____

## Primary Insurance Information

Insurance Company _____ Phone _____

Address _____ City _____ State _____ Zip _____

Policy Holder _____ SS# _____ D.O.B. _____

Group # _____ ID# _____ Effective Date _____/____/_____

Contact Person _____ Degree (LPC ok?) _____

Deductible $_____ Met? Yes $_____ No $_____ Paid by Insurance Co @ _____%

Family Deductible $_____ Met ?_____

Calendar Year Max $_____ Pre-Cert _____ Co-Pay Amount _____

Authorization Required?_____ Authorization #_____