CLIENT INTAKE, PAYMENT, AND CONSENT INFORMATION (rev. 8/2019)

Name: _____ Date of Birth: _____

First Date of Service: _____

Parent/Guardian Name (if minor): _____

Emergency Contact (name and Phone #): _____

How did you hear about me? _____

Can I thank them for the referral? _____ Contact Information: _____

PAYER INFORMATION (**Insurance Company, EAP, or self-pay*):

*Name of Primary Payer:	*Name of Secondary Payer:
Contact Information (800#, Payer ID, PO Box from card):	Contact Information (800#, Payer ID from card):
Primary Policy Holder (PPH) Name:	Secondary Policy Holder (SPH) Name:
PPH Date of Birth:	SPH Date of Birth:
PPH Phone Number:	SPH Phone Number:
PPH Address:	SPH Address:
Policy Group #	Policy Group #
Plan #/Type:	Plan #/Type:
Employer:	Employer:
Annual Deductible: Amt. Met:	Annual Deductible: Amt. Met:
Session Copayment Amt.:	Session Copayment Amt.:
Or Coinsurance (%):	Or Coinsurance (%):
Pre-Authorization needed If so, Auth #: # sessions authorized:	Pre-Authorization needed? If so, Auth #: # sessions authorized:

CLIENT INITIALS AND SIGNATURE:

_____I am giving permission to contact my *emergency contact person* in the event of a medical emergency.

_____I have been provided with information, and/or have read, policies relating to the *privacy of my health records*, and am aware that I may have a copy of this policy to take with me at my request.

_____I have been given and have read *the financial policy* of Sherry Hubbard, LIMHP/Great Plains Counseling, LLC. I understand that I may have a copy of this policy to take with me at my request, and consent to filing of claims and statements sent related to services rendered. I agree that I am financially responsible for services rendered.

_____I have been given and have read *information regarding my treatment/sessions* with Sherry Hubbard, LIMHP, MFT, PC, and consent to treatment.

Client: _____ Date: _____

Parent/Legal Guardian: _____ Date: _____