

LIFE ENRICHMENT CENTER LLC

2619 W. 6th St, Suite A

Lawrence, KS 66049

Phone: (785) 842-2752 www.lecnetwork.com Fax: (785) 842-2750

CLIENT INTAKE FORM

(PLEASE PRINT LEGIBLY! INFORMATION IN RED TYPE IS REQUIRED!)

Today's Date ____/____/____

Therapist _____

CLIENT INFORMATION

Client's Last Name		First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.	Marital Status (Circle One)	
						Single / Married / Other	
Is this your legal name?	If not, what is your legal name?		(Former Name)		Birth Date	Age	Sex
<input type="checkbox"/> Yes <input type="checkbox"/> No					/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Social Security	Home Phone No.	
					- -	()	
P.O. Box		City	State	ZIP Code	Cell Phone No.		
					()		
Occupation		Employer			Work Phone No.		
					()		
Referred to Provider by (Please check one box & list)				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Website
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to Home/Work		<input type="checkbox"/> Yellow Pages	
						<input type="checkbox"/> Other	
Email Address:				Alternative Email Address:			

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date	Address (if different)		Home Phone No.		
	/ /			()		
Email Address:			Cell Phone No.			
			()			
Occupation	Employer	Employer Address		Work Phone No.		
				()		
Is this client covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this an EAP visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		Total Annual EAPs allowed? _____	
Please Select Your Primary Insurance Provider		<input type="checkbox"/> Aetna <input type="checkbox"/> Assurant <input type="checkbox"/> Beech Street <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> ChoiceCare <input type="checkbox"/> Champus <input type="checkbox"/> Cigna <input type="checkbox"/> Freedom Health Network <input type="checkbox"/> First Health <input type="checkbox"/> HealthWave <input type="checkbox"/> Humana <input type="checkbox"/> Magellan <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> MHN/MHNet <input type="checkbox"/> PHCS <input type="checkbox"/> Principal <input type="checkbox"/> Meritain <input type="checkbox"/> TriCare <input type="checkbox"/> Unicare <input type="checkbox"/> United Healthcare <input type="checkbox"/> Value Options <input type="checkbox"/> Other _____				
		What is the authorization number? <input type="checkbox"/> Self Pay				
		Insured's Name	Insured's S.S. #	Birth Date	Group #	Policy #
				/ /		
Client's Relationship to Insured		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____				
Name of Secondary Insurance (if any) annnanapplicable)		Insured's Name	Group #	Policy #		
Client's Relationship to Insured		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____				

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Life Enrichment Center LLC

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Life Enrichment Center will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____
CLIENT/GUARDIAN SIGNATURE DATE