

Intake Cover Page for ADULTS

This form is required for your file. The information is needed for claims and/or auditing purposes. Please fill in all areas. "Client" & "Patient" refer to person seeking services. "Member" refers to the person who carries the insurance policy.

Client Name _____
FIRST NAME MIDDLE INITIAL LAST NAME

Client Address _____
STREET City State Zip Code

Primary Phone Number: _____ Accept texts? Yes No
Do we have permission to leave you a message at this number? Yes No

Secondary Phone Number: _____ Accept texts? Yes No
Do we have permission to leave you a message at this number? Yes No

INSURANCE INFORMATION* (Complete this section only if you wish for us to bill insurance company.)

Member's Name _____ Member's Employer _____

Insurance Carrier _____ Group # _____

Member ID # _____ Member's Date of Birth _____

Patient ID # _____ Patient's Date of Birth _____

Patient relationship to member: SELF SPOUSE CHILD/DEPENDENT

Refer to your insurance card for the following phone numbers: Member Services _____

Behavioral/Mental Health _____ Provider Hotline _____

*Providing this information does not guarantee insurance payment. Client assumes full responsibility for services.

Patient's Gender _____ Religious Preference (if you want us to know): _____

Patient's Marital Status Single Married Widowed Separated Divorced

Today's Date _____ Date of first scheduled appointment _____

Whom can we thank for your referral to North Shore Counseling?

PERSONAL REFERENCE _____

INTERNET: GOOGLE BING YAHOO OTHER _____

INSURANCE COMPANY WEBSITE _____

Emergency Contact (Name, Phone, & Relationship): _____

My counselor's name is _____

Session Fees & Copays: Due at the beginning of each appointment. Payment can be made by cash, check, credit card, or PAYPAL.

Checks should be made payable to North Shore Counseling, Ltd.