

INTAKE PACKET

Client Name: _____
DOB: _____
Today's Date: _____
Primary Insurance Name: _____ Policy #: _____
Secondary Insurance: _____ Policy #: _____
SSN: _____

IDENTIFYING INFORMATION

Home Address: _____ County: _____
Home Phone: _____ School/Grade: _____
Legal Guardian Name/Phone: _____
Mother's Name: _____ Daytime Phone: _____
Father's Name: _____ Daytime Phone: _____

EMERGENCY CONTACT

First Contact: _____ Relationship to Client: _____
Daytime Phone: _____ Evening Phone: _____ Cell: _____
Physician's Name/Phone: _____
Others in the Home (Names/Relationship to Client/Ages if appropriate): _____

Significant Others Involved with Client: _____

MENTAL HEALTH/BEHAVIORAL INFORMATION

Reason for Seeking Services: _____

Recent Treatment History (last 12 months): _____

Pertinent Medical Issues: _____

Client Medications: _____
Other Active Service Providers (last six months): _____
Court Involvement and/or Pending Charges: _____

CONSENTS/RIGHTS INFORMATION

1. Consent for Treatment

I hereby give my consent for **Therapist** to provide mental health services to me/my child. I have been informed of the scope and purpose of the service, and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time.

Client/Parent/Guardian: _____ Date: _____

2. Financial Release

I understand that **Therapist** may use confidential information about me to bill and be paid for services. I hereby consent for **Therapist** to release information to the billing agent, **Integrity Support, Inc.** and its contracted clearinghouse, and/or to the funding source, and for the funding source to release information to **Therapist** and **Integrity Support, Inc.** for this purpose.

Client/Parent/Guardian: _____ Date: _____

3. Permission to Transport

I hereby grant permission for **Therapist**, to provide transportation to my child, and agree to hold **Therapist** harmless for any accident/injury that results from the provision of transportation.

Client/Parent/Guardian: _____ Date: _____

4. Permission to Seek Emergency Medical Care

I hereby give consent for **Therapist**, to seek and sign consent for emergency medical care in the event that I am unable to do so for myself. It is understood that **Therapist** will attempt to locate me, or another legally responsible adult, as quickly as is possible in the emergency situation.

Client/Parent/Guardian: _____ Date: _____

5. Client Rights/Grievance Policies (See Handout)

I have received and had explained to me the Client Rights handout. **Therapist** gave me this handout and verbally explained my rights as a client.

Client/Parent/Guardian: _____ Date: _____

I. Privacy Rights (See Handout)

I have received and had explained to me the Privacy Rights handout. **Therapist** gave me this handout and verbally explained my rights concerning the privacy of information as a client. I understand these rights are designed to protect my privacy.

Client/Parent/Guardian: _____ Date: _____

I understand that one of my rights is to be able to choose how I am contacted.
I *do/do not* (please circle one) give permission for **Therapist** to contact me at work.
Furthermore, I *do/do not* (please circle one) give permission for **Therapist** to leave voice messages for me at *home/work/both/neither* (please circle one).

Client/Parent/Guardian: _____ Date: _____

I, **Therapist**, have explained and provided copies of the following: Client Rights/Grievance Procedure Handout; the Privacy Rights Handout; and the Service Description to the Client/Parent/Guardian of the client to be served.

Signature: _____ Date: _____

Print: _____