IMPACT
Impact Counseling & Consulting Services

**www.iccsmi.com**

800 IH West
San Antonio, TX 78230

625 Kenmoor Ave SE ,Ste 301
Grand Rapids, MI 49546

**CLIENT INTAKE FORM**
(Please Print)

**Today's Date ____/____/____** **Therapist: Joesph Lee, LPC**

## CLIENT INFORMATION

| Client's Last Name First Middle | Mr. Ms. | Marital Status (Circle One) Single / Married / Other |
|---|---|---|

| Is this your legal name? Yes No | If not, what is your legal name? | (Former Name) | Birth Date / / | Age | Sex M F |
|---|---|---|---|---|---|

| Street Address City State ZIP Code | Social Security - - | Home Phone No. ( ) |
|---|---|---|
| P.O. Box City State ZIP Code | | Cell Phone No. ( ) |
| Occupation / Employer | | May we leave a message? Yes No |

Referred to Provider by (Please check one box & list) Dr. _____ Insurance Plan Website

Family Friend Close to Home/Work Yellow Pages Other _____

| Email Address: | May we email you? Yes No<br>*Please note: Email correspondence is not considered to be a confidential medium of communication. |
|---|---|

## INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO BE COPIED)

| 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? Yes No | Is this an EAP visit? Yes No | Total Annual EAPs allowed? _____ |
|---|---|---|

**Please Select Your Primary Insurance Provider**

Amerigroup Assurant Beech Street Blue Cross/Blue Sheild ChoiceCare Champus
Cigna Definity Health First Health HealthSmart Humana Magellan/Aetna Medicaid
Medicare MHN/MHNet PHCS PMHS Texas One Choice TriCare Unicare
United Healthcare Value Options Other _____

What is the authorization number? Self Pay

| Insured's Name | Insured's S.S. # | Birth Date / / | Group # | Policy # | Co-Payment $ |
|---|---|---|---|---|---|

Client's Relationship to Insured Self Spouse Child Other _____

| Name of Secondary Insurance (if any) Insured's Name | Group # | Policy # |
|---|---|---|

Client's Relationship to Insured Self Spouse Child Other

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
No

Yes, previous therapist/practitioner: _____

## IN CASE OF EMERGENCY

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

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**I, _____, give full authorization to Impact Counseling and Consulting, LLC to furnish information regarding my mental health information to:**

**Name** _____ **Name** _____

**Address** _____ **Address** _____

**City, State, Zip** _____ **City, State, Zip** _____

**Name** _____ **Name** _____

**Address** _____ **Address** _____

**City, State, Zip** _____ **City, State, Zip** _____

**for the purpose of _____. This consent is subject to revocation by the undersigned, and remains in force for 365 days from the date of signature. By signing and dating this release of information, I allow the person listed below to share specific record information.**

**Name** **Joseph Lee, LPC**

**Impact Counseling and**

**Consulting, LLC**

_____

**Client's Signature**

_____

**Mental Health Representative**

_____

**Date**

# 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. _____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