Healing Connections
Client Intake Form

Date: _____ Account Number: _____

Client Last Name: _____ First Name: _____ Mid. Init: _____

DOB: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Contact and Message Phone Numbers (Please Include ***ONLY*** Numbers We May Call and Leave a Message)

Home: _____ Cell: _____ Work: _____ Other: _____

Social Security Number: _____ Church Affiliation: _____

Emergency or Appointment Contact Person: _____ Phone: _____

Referred to Us By: _____ Phone: _____

Personal Physician: _____ Phone: _____

List Current Medications: _____

List Any Allergies: _____

List Any Previous Counseling: When: _____ Where: _____

Reason for Counseling Today: _____

Employer: _____

Third Party Payor/Insurance Information

Insurance Company Name: _____ (Please Make Sure We Have a Copy of Your Ins. Card)

Employee Assistance Program Name: _____ Phone: _____

Other: Name: _____ Phone: _____

I hereby authorize:

1. The use of this form for all of my insurance submissions; 2. The release of necessary information to my insurance company or third party payor; 3. Direct payment to Healing Connections, LLC; and 4. A copy of this form to be used in place of an original.

Appointments: If you need to miss an appointment, please cancel with your counselor as soon as possible. Cancellations made less than twenty-four hours before a scheduled appointment will be charged directly to you at our full fee.

Fees: Payment is required at the time of service. We charge an additional $35.00 for any returned checks. Financial responsibility rests with the client regardless of any insurance coverage or third party payor.

I have read and understand the policies on appointment scheduling and payment of fees.

Signed (Client): _____ Date: _____

Signed (Responsible Party): _____ Date: _____