ARBOR COUNSELING CENTER **Intake Form**

Date: ___________________________

CLIENT INFORMATION:

Social Security #: _______-_______-_______

Client Name: ____ DOB: ____/____/_______ Age: ______

Address: ____City:_______________________Zip:___________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

May we text you appointment reminders? Y N At which phone(s) may we leave a message? H ____C____ W_____

E-Mail Address: ____ May we email you practice information? Y N

Marital Status: Married____ Single____ Divorced____ Widowed____ Partnered____

If Married/Partnered, how long: ____________ Spouse's/Partner's name: __________________________________

Name of **GUARDIAN** and relationship if Client is under 18 years old: ____

Guardian Cell Phone: ____________________ Guardian Work Phone: ____________________

May we text you appointment reminders? Y N At which phone(s) may we leave a message? C____ W_____

Other important people for the client:

NAME	*AGE*	*RELATIONSHIP*

BENEFIT INFORMATION:

If you are utilizing an Employee Assistance Program (EAP) benefit, please enter the following:

Employee: _________________________ Date of Birth: _____/_____/__________ Employer: ___________________

EAP Company: _____________________ Number of Sessions: _____ Authorization #: ___________________________

If you are utilizing an Insurance benefit, please enter the following:

Policyholder: _______________________ Date of Birth: _____/_____/__________ Employer: ___________________

Policyholder Address: ____

Name of Insurance Company: ____

Insurance ID Number: _______________________ Insured Group Number: ________________________________

ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Arbor Counseling Center to submit claims for benefits for services rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Signature of Subscriber: ____

What made you choose Arbor Counseling Center? *(√Check **all** boxes that apply.)*

- ☐ I am a returning client
- ☐ Another Arbor client recommendation
- ☐ Arbor Counseling Center website
- ☐ Other therapist recommendation____________________
- ☐ School recommendation ____________________________
- ☐ Hospital/Doctor recommendation ___________________
- ☐ Church/synagogue/mosque recommendation___________
- ☐ Insurance company
- ☐ Employee Assistance Program
- ☐ Internet________________________________
- ☐ Other _________________________________

Office Use Only RFV:
Therapist: