



Intake Paperwork

PATIENT INFORMATION:

Date _____ Client's Social Security # _____ Case # _____
 Client's First Name _____ Last Name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 Telephone(Home) _____ (Work) _____
 Birth date _____ Age _____ Gender _____ F M _____ Race __ Name of
 Spouse/Guardian _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 Person Responsible for Payment _____ Soc. Sec. # _____
 Signature of Person Responsible for Payment X _____ (Must be signed for services to begin)

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, CONTACT:

Name(1) _____ Relationship _____ Phone _____ Work _____
 Address _____ City _____ State _____ Zip _____
 Name(2) _____ Relationship _____ Phone _____ Work _____
 Address _____ City _____ State _____ Zip _____
 Physician _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 Psychiatrist _____ Phone _____ Address _____
 _____ City _____ State _____ Zip _____
 Other Physicians _____ Phone _____
 Current Medications _____
 Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs. _____
 Spouse: Place _____ Phone _____ Hrs. _____

INSURANCE INFORMATION

INSURANCE INFORMATION: (Present Insurance Card to Office Staff Please)

Primary Insurance Company: _____ Secondary Insurance Company: _____

Card Holder _____ Card Holder _____

Birth Date _____ Birth Date _____

SSN _____ SSN _____

Address _____ Address _____

Phone # _____ Phone # _____

Employer _____ Employer _____

Policy ID # _____ PolicyID# _____

Group # _____ Group # _____

REFERRAL SOURCE

HOW DID YOU HEAR OF OUR CLINIC(OR FROM WHOM) ?

Address _____ City _____ State Zip _____

Phone _____ Relationship to referral source _____ Primary doctor _____

RESTRAINING ORDER OR ORDER OF PROTECTION

Is there currently a Restraining Order or Order of Protection on anyone? YES /

NO If so,what is the name of the individual(s)? _____

BILLING INFORMATION – Read and sign:

- 1. I authorize Elevate Mental Health to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, agency accountant(s), agency legal representatives, Elevate Mental Health Supervisor, and insurance companies and carriers who may be responsible for payment of benefits.
 - 2. I authorize Elevate Mental Health to release my medical records and billing information to my Primary Care and/or Referring Physician.
 - 3. I authorize my insurance benefits to be paid to Elevate Mental Health
 - 4. If a requested insurance claim is filed, I will receive a bill eachmonth if my account has a balance due. Iam responsible for any charges not paid by insurance.
 - 5. I understand that if I do not provide the above insurance information, I will be responsible for my bill,regardless of whether or not I have insurance.
 - 6. I understand that I am responsible for providing a referral to my insurance company if they require it.
- Name of person completing this form (please print) _____

Signature of person completing this form _____ Date: _____

Relationship to Patient: _____