Dawn Wade, MA, ATR, CHT, LMFT

Licensed Marriage and Family Therapist
Certified Hypnotherapist Registered Art Therapist
3175 Sunset Blvd., Suite 104 Rocklin, CA 95677
CA License MFC #53765 National Registration ATR #13-048
916-905-4278 Dawn@heartmindandhealth.com

NEW CLIENT INTAKE FORM

Date:_____

(#1)Client name: _____ **(#2)Client name:** _____

Single_____ Partnership_____ Married_____ Separated_____ Divorced_____ Other_____

Street Address:_____City:_____Zipcode:_____

Mailing Address:_____City:_____Zipcode:_____

(#1) Birthdate:_____ Age:_____ SSN:_____ Driver's License#_____

(#2) Birthdate:_____ Age:_____ SSN:_____ Driver's License#_____

(#1)Home
Ph#_____Cell#_____Work#_____Email:_____

(#2)Home
Ph#_____Cell#_____Work#_____Email:_____

(#1)Employer:_____Occupation:_____

(#2)Employer:_____Occupation:_____

Emergency Contact:_____Ph#_____

Relationship with Emergency Contact:_____
(If it becomes necessary to contact this individual, only information required to keep you safe will be disclosed.)

My Therapist may call me at my home	_____yes ____no	Explanation if needed_____
My Therapist may call me on my cell	_____yes ____no	_____
My Therapist may call me at work	_____yes ____no	_____
My Therapist may email me	_____yes ____no	_____
My Therapist may text message me	_____yes ____no	_____

Family Physician:_____Ph#_____
Please list medications currently taking (including supplements):

_____ _____

_____ _____

_____ _____

_____ _____

How were you referred you to me?_____ Are you being court-ordered for therapy? ____ yes ____no
Previous Counseling? _____yes ____no When?_____

Briefly explain your current needs and hopes for therapy_____
_____
_____
_____
_____

_____ _____

(#1)Client or Authorized Person's/Guardian's Signature **(#2)Client or Authorized Person's/Guardian's Signature**

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CLIENT INSURANCE FORM

Date:_____

Client name(s):(#1)_____ (#2)_____

Primary Insured's Name:_____& **SSN:**_____

Primary Insured's Birthdate:_____ **Relation to Client**:_____

Street Address:_____City:_____Zipcode:_____

Mailing Address:_____City:_____Zipcode:_____

Home
Ph#_____Cell#_____Work#_____Email:_____

Employer:_____ Occupation_____

Insurance Co:_____ ID#_____ Group#_____

Note: Without prior authorization, your insurance company may refuse payment and you could be responsible for the entire fee. AUTHORIZATION OBTAINED? Yes_____ No_____

Clients who carry insurance should remember that the Client, not the insurance company, is responsible for payment. I will bill your insurance company for you if I am a provider for your particular plan.

Please understand that by requesting insurance reimbursement, you may be asked to waive your confidentiality. Your insurance company may request information concerning your treatment in order to process your claim and/or to grant additional sessions.

You will be required to pay for services at each session. If your insurance company/third party payor denies payment or makes partial payment, the balance will be due upon notification and/or charged to your credit card within 24 hours unless other arrangements are made.

The following *TWO* signatures are needed in order to file your insurance claim. Failure to sign may result in denial of your claim.

_____
Client or Authorized Person's/Guardian's Signature

I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits to Dawn Wade, MA, LMFT.

_____
Insured's or Authorized Person's Signature

I authorize payment of medical benefits to Dawn Wade, MA, LMFT. I understand I am financially responsible for debts incurred by my dependents or by me.