



Solutions Therapeutic Services

109 Central Ave.
Cartersville, GA 30120
(770)383-8909
(770)383-8930-fax

CLIENT INTAKE INFORMATION FORM

Client's Name _____ DOB: _____ M ___ F ___

Significant Other/Parent's Name(s): _____ DOB: _____

Address: _____ Y ___ N ___ Phone: _____ Y ___ N ___
Permission to mail: _____ Permission to call/leave message: _____

City/Zip: _____ Alternate Phone _____ Y ___ N ___

Marital Status: _____ Email: _____

Employer/School: _____ Referral Source: _____

Children(s)/Sibling(s) First and Last Names (use back if necessary) Birth Date Sex

Briefly describe the reason(s) for seeking help: _____

Prior Therapy Experience: _____

Place of Employment: _____

Name of Health Insurance: _____ ID#: _____

Group # / Name: _____ Primary SSN _____

Primary insured's Name: _____ DOB: _____ M ___ F ___

Authorization #: _____ Co-Pay: _____

Primary Care Physician's Name/Date of last Appt.: _____

Allergies: _____ Medical Problems: _____ Medications: _____

By signing below, I authorize the release of any medical (PHI) or other information necessary to process an insurance claim. I attest that my therapist will do all that is necessary to file insurance benefits on my behalf, and I authorize payment of medical benefits to my therapist directly. However, as the insured, I am responsible for paying any co-pays due on the date of service. I am also ultimately responsible for any denied claims that were properly filed in a timely manner.

Authorized Signature

Date