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:____________________

Permission to mail: Permission to call/leave message:

Address: ______________________________Y__N__ Home Phone: ______________________Y__N__

City/Zip: ______________________________________ Work Phone: ______________________Y__N__

Marital Status: ________________________________ Cell / Pager: _______________________Y__N__

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: ____

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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