Benjamin Counseling Center

Empowering, Encouraging, Improving Lives

NEW CLIENT INTAKE FORM

CLIENT INFORMATION:

Name: Last _____ First: _____ Middle Initial: ___

Address: _____

City: _____ State: _____ Zip code: _____

Date of Birth: _____ Age: ____ Sex: ____ Relationship Status: _____

Phones: (W) _____ (H) _____ (C) _____

Email Address: _____

Place of Employment: _____

Referred by: _____ Reason for Therapy: _____

PARENT OR GUARDIAN CONTACT INFORMATION (If Client is under 18):

Name_____ Relationship to Client: _____

Phones: (W) _____ (H) _____ (C) _____

Email Address: _____

CLIENT HEALTH INFORMATION:

Name of Insurance Co._____ Phone Number: _____

Insurance ID Number: _____ Group Number: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Place of Employment: _____

Do you have any authorizations for mental health treatment? _____

If yes, please list: _____

Cancellation Policy

A 24-hour advance notice is required for cancellation of your scheduled appointment. A missed appointment fee of **$60.00** will be charged.

Certification and Authorization

I certify that the above information is correct. I authorize the release of any medical information necessary to process this claim. I request that payments be made directly to **Benjamin Counseling Center** on my behalf. Therefore my signature will be on file to file with my insurance company.

Signature of Client/Guardian: _____ Date: _____