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### CLIENT INTAKE FORM

Today's Date \_\_\_\_\_

CLIENT INFORMATION		(Please Print)	
Last Name	First Name	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other:
Other Name <input type="checkbox"/> Legal <input type="checkbox"/> Former	Birthdate / /	Age	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
Street Address		P.O. Box	
Home Phone	Cell Phone	Work Phone	Other (fax, pager, etc.)
Email Address		Alternate Email Address	
Occupation		Employer	
Referred to Metta by: <input type="checkbox"/> Psychology Today Website <input type="checkbox"/> Metta Website <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Other:			

CHILD'S MOTHER INFORMATION			
Last Name	First Name	Age	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other:
Street Address		P.O. Box	
Home Phone	Cell Phone	Work Phone	Other (fax, pager, etc.)
Occupation	Employer	Email	
Stepparent with Mother Last	First Name	Age	Contact Information:
Occupation		Employer	

CHILD'S FATHER INFORMATION			
Last Name	First Name	Age	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other:
Street Address		P.O. Box	
Home Phone	Cell Phone	Work Phone	Other (fax, pager, etc.)
Occupation	Employer	Email	
Stepparent with Father Last	First Name	Age	Contact Information:
Occupation		Employer	

EMERGENCY CONTACT		
Last Name	First Name	Contact Information:

## INSURANCE INFORMATION

Client's Last Name	First Name	Birthdate / /	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
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Member's Last Name	First Name	Birthdate / /	
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Member ID Number	Member Group Number	Effective Date
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Insurance	Benefit's Phone	Pre-Certification Phone	Other Phone
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Behavioral Health Company	Benefit's Phone	Pre-Certification Phone	Other Phone
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Mail Claims to:
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Benefits In Network	Deductible	Family Individual	Amount of Deductible met
<input type="checkbox"/> Co-Pay	<input type="checkbox"/> Co-Insurance	<input type="checkbox"/> % Paid by Insurance	Number of Sessions:

Benefits Out-of-Network	Deductible	Family Individual	Amount of Deductible met
<input type="checkbox"/> Co-Pay	<input type="checkbox"/> Co-Insurance	<input type="checkbox"/> % Paid by Insurance	Number of Sessions:

## INSURANCE INFORMATION GATHERING PROCESS

Called for Benefits	Date	Spoke with	Confirmation #
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Called for Pre-Certification	Date	Spoke with	Confirmation #
Number of Sessions Authorized			

Called for:	Date	Spoke with	Confirmation #
Information Gathered:			

Called for:	Date	Spoke with	Confirmation #
Information Gathered:			

Called for:	Date	Spoke with	Confirmation #
Information Gathered:			

Called for:	Date	Spoke with	Confirmation #
Information Gathered:			

Called for:	Date	Spoke with	Confirmation #
Information Gathered:			