Lakes Area Counseling
New Patient Intake Form

Date: ____________

Name:______________________________________ Age:______ Date of Birth:_______________

Address:____________________________________ Phone:________________________________

____________________________________ Social Security #:________________________

Parent/Guardian (if child):___________________________________ Phone:__________________

Address:____________________________________

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Referral Source:____ Phone:__________________

Insurance Company:_______________________________

Identification #:___________________________________ Group #__________________

Claims Address:____

Insurance Phone Number: _________________________

Subscriber Name:______________________________ Social Security #:________________________ (if available)

Subscriber Date of Birth: _________________ (if on insurance card)

Subscriber's Employer:___________________________________

Please attach copy of insurance card if available

Benefit Assignment and Consent for Treatment

I HEREBY AUTHORIZE Lakes Area Counseling to release any information necessary to process my insurance/medicaid claim, acquired in the course of my examination or treatment: to allow a photocopy of my signature to be used to process my insurance/Medicaid claim for the period of one year from signature date or until termination of services. I claim any insurance benefits due me for services rendered Lakes Area Counseling, and authorize and direct my carrier to issue payment check (s) directly to Lakes Area Counseling. Regardless of my insurance benefits, if any, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full.

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

I hereby authorize the performance of psychological services including individual, group, or family therapy (as appropriate), assessment, and psychological testing.

I hereby release Lakes Area Counseling from any liability relating to, and agree to hold Lakes Area Counseling and its employees and independent contractors harmless from any effects caused directly or indirectly from psychological services including diagnostic testing, and evaluation.

____ ____________________

Patient/Responsible Party Signature Date