CLIENT NAME:

CLIENT DOB:

CLIENT SSN:

GENDER:

LEGAL GUARDIAN NAME(S) IF CLIENT IS A CHILD:

PHONE NO:
EMAIL:
PERMISSION TO TEXT:
PERMISSION TO EMAIL:
REASON FOR SEEKING SERVICES:

PRIMARY INSURANCE:
POLICY #:

SECONDARY INSURANCE:
POLICY #:

REFERRED BY:

SPECIFIC THERAPIST REQUESTED:
PREFER FACE-TO-FACE OR TELEHEALTH:
SCHEDULING NEEDS:

ONLINE REFERRALS ARE RECEIVED DURING REGULAR BUSINESS HOURS. UPON RECEIPT, INTAKE DOCUMENTS WILL BE SENT TO THE EMAIL PROVIDED. ONCE THOSE DOCUMENTS ARE RECEIVED AND INSURANCE IS VERIFIED, WE WILL ASSIGN YOU TO A CLINICIAN WHO WILL THEN SCHEDULE YOUR FIRST APPOINTMENT.
THINGS TO KNOW:

- **COPAYS AND NON-INSURANCE SERVICE PAYMENTS ARE DUE AT THE TIME OF SERVICE**
- **IF YOU HAVE JOINT CUSTODY OF A CHILD, SIGNATURES ARE REQUIRED FROM BOTH PARENTS.**

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