Overcomers Counseling, LLC

(404)-518-5705

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__ Phone: _____________________Y__N__

City/Zip: ____________________________________ Alternate Phone_____________________Y__N__

Marital Status: _______________________________ Email: __________________________________

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