

Hollie Wilson Counseling
 2000 Highland Village Road, Suite C
 Highland Village, TX 75077
 Phone: (205)238-1207
www.holliewilsoncounseling.com

CLIENT INTAKE FORM

(Please Print)

Today's Date ____/____/____ Therapist: Hollie Wilson, LCSW-S **CLIENT INFORMATION**

Client's Last Name First Middle			<input type="checkbox"/> Mr. <input type="checkbox"/> Ms.		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Other	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)		Birth Date //	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address City State ZIP Code			Social Security --		Home Phone No. ()	
P.O. Box City State ZIP Code				Cell Phone No. ()		
Occupation		Employer			Work Phone No. ()	
Email Address:		Alternative Email Address:			On which phone numbers may we leave a message? <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Referred to Provider by (Please check one box & list) <input type="checkbox"/> Doctor _____ <input type="checkbox"/> Attorney _____ <input type="checkbox"/> Court <input type="checkbox"/> Insurance <input type="checkbox"/> Web Search <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Online Search <input type="checkbox"/> Other						

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER) Person Responsible for Bill Birth Date Address (if different) Home Phone No.

Email Address:				Cell Phone No. ()	
Occupation	Employer	Employer Address			Work Phone No. ()
Is this client covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this an EAP visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		Total Annual EAPs allowed? _____	
Please Select Your Primary Insurance Provider		<input type="checkbox"/> Aetna <input type="checkbox"/> Amerigroup <input type="checkbox"/> Beech Street <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> ChoiceCare <input type="checkbox"/> Champus <input type="checkbox"/> Cigna <input type="checkbox"/> Definity Health <input type="checkbox"/> First Health <input type="checkbox"/> HealthSmart <input type="checkbox"/> Humana <input type="checkbox"/> Magellan <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> MHN/MHNet <input type="checkbox"/> PHCS <input type="checkbox"/> PMHS <input type="checkbox"/> Texas One Choice <input type="checkbox"/> TriCare <input type="checkbox"/> United Healthcare <input type="checkbox"/> Value Options <input type="checkbox"/> Other _____ <input type="checkbox"/> No Insurance / Self Pay			
What is the authorization number?					
Insured's Name	Insured's S.S. #	Birth Date //	Group #	Policy #	Co-Payment \$
Client's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of Secondary Insurance (if any)		Insured's Name		Group #	Policy #
Client's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address) Relationship to Client Home Phone No. Work Phone No.

Hollie Wilson Counseling

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Hollie Wilson, LCSW will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance for services rendered.

X

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X

CLIENT/GUARDIAN SIGNATURE DATE

I understand that by giving the above named individuals and phone numbers for emergency contact that I am providing consent for reasonable communication to these individuals.

x _____ CLIENT/GUARDIAN SIGNATURE I authorize the payment of medical benefits to the provider of services.

X

CLIENT/GUARDIAN SIGNATURE DATE