

FOR OFFICE USE ONLY
First Date of Treatment _____
DSM Code # _____
<input type="checkbox"/> Check here if this is a returning patient

Intake Form for Shelley Janiczek Woodson, Ph.D.

Please fill out this form and bring it to your first session. Please note: the answers you provide here are protected as confidential information.

A. Personal Information:

Client Name _____
(Last) (First) (Middle Initial)

Preferred Name _____
(Last) (First) (Middle Initial)

Date of Birth _____ Social Security Number _____

Address _____

City/State/Zip _____

Home Phone () _____ May we leave a message Yes No

Cell/Other Phone () _____ May we leave a message Yes No

Email _____ May we email you Yes No

* Please note: email correspondence is not considered to be a confidential medium of communication.

Gender _____ Preferred Pronoun(s) _____

Sexual Orientation (feel free to decline to answer) _____

Relationship Status Never Married Domestic Partnership Married
 Separated Divorced Widowed

Please list any children/ages _____

Primary Care Physician _____ Office Phone () _____

Referred by (if any) _____

B. Responsible Party: (Fill in if under 18 or if someone other than patient is responsible for payment)

Name _____
(Last) (First) (Middle Initial)

Address _____

City/State/Zip _____

Home Phone () _____ Cell/Other Phone () _____

Relationship to Patient _____

Second Responsible Party _____

C. Insurance Information:

Primary Insurance Company _____

Address _____

City/State/Zip _____ Phone () _____

Name of Insured (if different from patient) _____ DOB _____

Insurance ID# _____ Group # _____

Secondary Insurance Company _____

Address _____

City/State/Zip _____ Phone () _____

Name of Insured (if different from patient) _____ DOB _____

Insurance ID# _____ Group # _____

D. Authorization for Release of Information and Assignment of Benefits for Insurance

I authorize the use or disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Signed _____ Date _____

I authorize payment of medical benefits to my provider for services performed.

Signed _____ Date _____

Sections E, F, and G Will Be Filled Out by Office Staff

E. Insurance Coverage Information:

Annual Deductible _____

Insurance Coverage per Session 100% 80% 50% Other _____

How Much Coverage per Calendar Year? \$ _____ or Number of Sessions _____

Copayment per Session \$ _____ Other _____

F. Authorization Information:

Authorization # _____ Number of Sessions Authorized _____

Date Authorization Starts _____ Date Authorization Ends _____

For Authorization Call () _____ Ext. ____ Fax () _____

Authorization Covers Types of Service Codes (check all that apply)

90801 90806 90808 90847 96117 Other _____

G. Billing Information: (Check all that apply)

Send Claims to Primary Insurance Send Claims to Secondary Insurance

Send Bills for Copayment/Deductible to Client or Responsible Party

Patient Pays in Full at Session or Responsible Party Pays in Full at Session

Send Claims to Insurance But Collect in Full from Patient or Responsible Party

Special Instructions _____