INITIAL INTAKE FINANCIAL INFORMATION

For under 18 years

Client Information

Name: _____ Home Phone: _____
Address/City/State/Zip: _____
Date of Birth: _____ Age: _____ Gender: Male: ____ Female: ____ Grade: _____

School District: _____
School: _____

General Reason for Referral:
___ Grieving ____ Moody
___ Home Issues ____ Uncooperative
___ School Issues ____ Other: _____

Ethnicity:
🕘 Anglo 🕘 Hispanic 🕘 African-American 🕘 Asian 🕘 Decline 🕘 Other: _____

Faith: _____ Attend?_____

Parent/Guardian Information

Relationship to Client: _____ Home Phone: _____
Name: _____ Work Phone: _____
Address: _____ Cell Phone: _____
City/State/zip: _____ Date of Birth: _____
SSN: _____

Relationship Status: ___ Single ___Committed Relationship ___ Married ___ Divorced

Please indicate the phone number you want to be contacted at: _____
Email:_____

Primary Insurance Company Information

Ins. Co Name: _____ Employer:_____
Phone: _____ Policy Holder: _____
ID Number: _____ Policy Holder's Address: _____
Policy Number: _____ _____
Group Number: _____ Policy Holder's Home Phone: _____
Relationship to Client: _____ Policy Holder's Work Phone: _____
SSN of Policy Holder: _____ Policy Holder's Date of Birth: _____

Secondary Insurance

Ins. Co Name: _____ Employer: _____
Phone: _____ Policy Holder: _____
ID Number: _____ Policy Holder's Address: _____
Policy Number: _____ _____
Group Number: _____ Policy Holder's Home Phone:_____
Relationship to Client: _____ Policy Holder's Work Phone: _____
SSN of Policy Holder: _____ Policy Holder's Date of Birth: _____

Payment Policy

All services rendered are the financial responsibility of the client or the client's parent or guardian. The client is responsible for the payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement from private insurance carriers. **Authorization of Payment:** I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered.

ACKNOWLEDGMENT OF REFERRAL

It is my practice to acknowledge and thank members of the professional community for their trust in referring persons to me. Your signature below gives me permission to make such contact by phone or letter.

Referred by:

🕘 Pediatrician 🕘 Minister 🕘 Psychologist 🕘 Psychiatrist 🕘 School 🕘 Other

Name of Referring Individual: _____

Street Address: _____ City:_____ Zip:_____

Phone: _____

Initial: _____

Signed: _____

Initial: _____

Print Name: _____

Relationship to Client: _____

Date: _____

CANCELLATION AND RETURNED CHECK POLICIES

Because counseling hours are reserved, Julie Gowen will charge for sessions canceled when less than 24 hours notice is given. This fee will **not** be billed to your insurance company. This fee must also be paid in full at the time of your next session.

There will be a $35 charge for each returned check.

I have read and understand these policies.

Initial_____

I attest all of the above to be true and that I will in good faith abide by the policies set forth above:

Signature: _____ Date: _____