

ECAR Counseling and Evaluation Services CLIENT/PATIENT INTAKE FORM

(Please Print) **Part 1 & 2**

Today's date:				PCP:			
CLIENT/PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (<u>circle one</u>) : Partner/ Single / Mar / Div / Sep / Wid	
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:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Referred to agency by (please check at least one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> DSHS
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other		
Other family members or friends seen here:							

PAYMENT/INSURANCE INFORMATION							
(Please give your insurance card to the therapist/ receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please check primary insurance/payment source:		<input type="checkbox"/> Healthy Options/Basic Health	<input type="checkbox"/> Court Ordered	<input type="checkbox"/> DSHS		<input type="checkbox"/> Foster Care Licensing	<input type="checkbox"/> Child Care Licensing
<input type="checkbox"/> Molina Insurance	<input type="checkbox"/> Adoption Support	<input type="checkbox"/> FPS/FRS	<input type="checkbox"/> CSO (<i>Please provide voucher</i>)		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:		Policy no.:
Patient's relationship to subscriber:		<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 patient:		Home phone no.: ()	Work phone no.: ()	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize <i>ECAR Counseling and Evaluation Services</i> or the insurance company/agency to release any information required to process my claims.							
_____ <i>Patient/Guardian signature</i>						_____ <i>Date</i>	