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:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:		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):**	☐ Dr.	☐ Insurance Plan	☐ DSHS

☐ Family	☐ Friend	☐ Close to home/work	☐ Group Health	☐ 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? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.:

Is this patient covered by insurance? ☐ Yes ☐ No

Please check primary insurance/payment source:	☐ Healthy Options/Basic Health	☐ Court Ordered	☐ DSHS	☐ Foster Care Licensing	☐ Child Care Licensing

☐ Molina Insurance	☐ Adoption Support	☐ FPS/FRS	☐ CSO *(Please provide voucher)*	☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ 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 *ECAR Counseling and Evaluation Services* or the insurance company/agency to release any information required to process my claims.

Patient/Guardian signature ***email address:*** *Date*