Phone: 954-507-0137 www.InwardBoundJourneys.com Wilton Manors, Florida

CLIENT INTAKE FORM

Today's Date _____/_____/_____ (Please Print)

CLIENT INFORMATION

Client's Last Name	First	Middle	Marital Status (Circle One) Single / Married/ Domestic Partner/ Widowed/ Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Gender Identity

Street Address	City	State	ZIP Code	Occupation	Employer

Email Address (completion of this provides permission to send emails from Inward Bound)	Home Phone No. ( )

Cell Phone No.

( ) Permission to accept text messages: _____ Yes _____ No

Referred to Provider by (Please check one box & list) ❑ Dr. _____ ❑ Insurance Plan ❑ Website

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date / /	Address (if different)	Social Security Number
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Home Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? _____

Please Select Your Primary Insurance Provider ❑ Self Pay

❑ Aetna ❑ AvMed ❑ Beacon ❑ Magellan ❑ Humana ❑ Medicare ❑ Other_____

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

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

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.

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 due prior to a decision to stop.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

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

X _____

CLIENT/GUARDIAN SIGNATURE DATE