



Intake Cover Page for ADULTS

This form is required for your file. The information is needed for claims and/or auditing purposes. Please fill in all areas. "Client" & "Patient" refer to person seeking services. "Member" refers to the person who carries the insurance policy.

Client Name _____

FIRST NAME MIDDLE INITIAL LAST NAME

Client Address _____

STREET CITY STATE ZIP CODE

Primary Phone Number: _____ Accept texts? Yes No

Do we have permission to leave you a message at this number? Yes No

Secondary Phone Number: _____ Accept texts? Yes No

Do we have permission to leave you a message at this number? Yes No

Patient's Gender _____ Religious Preference (if you want us to know): _____

Patient's Marital Status: Single Married Widowed Separated Divorced

.....
INSURANCE INFORMATION* (Complete this section only if you wish for us to bill insurance company.)

Member's Name _____ Member's Employer _____

Insurance Carrier _____ Group # _____

Member ID # _____ Member's Date of Birth _____

Patient ID # _____ Patient's Date of Birth _____

Patient relationship to member: SELF SPOUSE CHILD/DEPENDENT

Refer to your insurance card for the following phone numbers: Member Services _____

Behavioral/Mental Health _____ Provider Hotline _____

*Providing this information does not guarantee insurance payment. Client assumes full responsibility for services.
.....

Today's Date _____ Date & Time of first scheduled appointment _____

Therapist Assigned: _____ Supervisor (if applicable): _____

Whom can we thank for your referral to Bellosa Counseling, LLC? PERSONAL REFERENCE _____

INTERNET: GOOGLE YAHOO INSURANCE COMPANY _____ OTHER _____

Emergency Contact (Name, Phone, & Relationship): _____

Session Fees & Copays: Due at the beginning of each appointment. Payment can be made by cash, check, or credit card. **Checks should be made payable to Bellosa Counseling, LLC.**