CLIENT INTAKE FORM - ADULT

Please print clearly.

Today's Date: _____ / _____ / _____

First Name: _____ **MI:** _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Birthdate: _____ / _____ / _____ **Gender:** ☐ **Male** ☐ **Female** ☐ _____

Primary Phone: (**)** _____ **Secondary Phone: (** **)** _____

Email Address: _____

Clinician's Name: _____ **Referred By:** _____

Responsible Party: Self _____ **Other:** _____

May we leave messages identifying our agency (circle)? Yes No

Insurance Carrier: _____

Primary Insured's Name: _____

Primary Insured's Birthdate: _____ / _____ / _____

Primary Insured's Address: _____

_____

Primary Insured's Phone: (**)** _____

Emergency Contact Name: _____

Emergency Contact Phone: (**)** _____

NOTE: If insurance is filed by Groff & Associates, all **standard billing rates** must apply. If you are paying a reduced rate and try to file an insurance claim on your own, it constitutes *insurance fraud* and we will not release the information needed by the insurance company to process the claim.