Client Intake Form

Gony Halevi MA, LMHC

Client Name: _____ Date of Birth: _____Date of First Visit:_____

Address: _____ City, State_____ Zip_____

Home Phone: _____ Work Phone _____ Mobile Phone: _____

Can insurance and billing information be sent to the address above? ☐ Yes ☐ No

How did you hear of us? _____

Sex: ☐ **Male** ☐ **Female**

Relationship Status: ☐ **Single** ☐ **Married** ☐ **Other**

Employment: ☐ **Employed** ☐ **Full-Time Student** ☐ **Part-time Student**

Emergency Contact: _____ Contact's Phone:_____

During the past year have you been seen elsewhere for mental health services? ☐ Yes ☐ No

If so, where: _____Type of therapy: ☐ Individual ☐ Family/Couple

Other Therapist Name: _____Phone:_____

PCP Name: _____Phone:_____

☐ Medication Management:_____

	Primary Insurance	**Secondary Insurance**
Insurance Carrier Name:		
Policy #:		
Subscriber on Policy:		
Subscriber Date of Birth:		

Our office **DOES NOT GUARANTEE** that your insurance provider will reimburse your therapy services. As the client, it is your responsibility to be aware of your health care/mental health benefits. If your insurance provider does not pay or respond to all/any claims filed, you will then be responsible for payment.

RELEASE, ASSIGNMENT AND RESPONSIBILITY: I authorize the release of information which is necessary to the process of my (and my dependent's) insurance claims, and request payment directly to **Gony Halevi, LMHC.** Also, I accept responsibility for any charges that my insurance company may not pay for.

Signed: _____Relation to Patient: _____
(if not signed by patient)

Printed Name: _____ Date of Signature: _____