Journey of Hope Counseling
11224 86th Ave N.
Maple Grove, MN 55369
Phone: (763) 400-7076 **Fax: (763) 400-7078**

CLIENT INTAKE FORM

(Please Print)

Today's Date _____/_____/_____ **Therapist____________________**

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr.	Marital Status (Circle One) ❑ Ms. Single / Married / Other

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

Street Address	City	State	ZIP Code		Home Phone No. ( )
P.O. Box	City	State	ZIP Code		Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. __________ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other __________________

Email Address:	Alternative Email Address:

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

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

Occupation	Employer	Employer Address	Work 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

❑ Blue Cross/Blue Shield
❑ Cigna ❑ Definity Health ❑ Health Partners ❑ Humana
❑ Medicare ❑ Medica ❑ PHCP ❑ Preferred One ❑ Medicaid/MA
❑ United Healthcare ❑ Value Options ❑ Other ____________________

What is the authorization number?	❑ Self Pay

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

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

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

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	Home Phone No.	Work Phone No.

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am ultimately responsible for the payment of therapeutic services rendered. If you plan to use your private insurance, it is important to provide your therapist with proper up-to-date information required to submit to insurance claims on your behalf. All out of network services, insurance deductibles and co-payments are the responsibility of the client.

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 reimbursement purposes.

X

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X

CLIENT/GUARDIAN SIGNATURE DATE