**Waverly J Hanson, MA**

***Licensed Professional Counselor, Licensed Relationship Coach***

1901 Malton Court

Castle Rock, CO 80104

**Phone: (719) 661-7330**

**CLIENT INTAKE FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Today’s Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **Therapist: Waverly J Hanson** |  |
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| **CLIENT INFORMATION** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Client’s Last Name |  |  |  |  |  | First |  |  |  |  |  | Middle |  |  |  |  Mr. |  |  Ms. |  |  | Marital Status (Circle One) |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Single / Married / Other |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Is this your legal |  | If not, what is your legal name? |  |  |  | (Former Name) |  |  |  |  |  |  |  |  | Birth Date |  |  | Age |  | Sex |  |
| name? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  Yes |  No |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | / |  |  | / |  |  |  |  | MF |  |
| Street Address |  |  |  | City |  |  |  | State |  |  |  | ZIP Code |  |  |  |  | Social Security |  |  | Home Phone No. |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | - | - |  |  |  |  |  |  | ( |  | ) |  |  |  |  |  |  |
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| P.O. Box |  |  |  |  |  |  |  | City |  |  |  |  |  |  |  | State |  |  |  |  | ZIP Code |  |  | Cell Phone No. |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ( |  | ) |  |  |  |  |  |  |
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| Occupation |  |  |  |  |  | Employer |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Work Phone No. |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ( |  | ) |  |  |  |  |  |  |
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| Referred to Provider by (Please check one box & list) |  |  |  |  |  |  Dr. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  Insurance Plan |  Website |  |
|  Family |  Friend |  Close to Home/Work |  |  |  Yellow Pages |  |  |  |  |  Other |  |  |  |  |  |  |  |  |  |  |  |  |
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| 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. |  |  |  |
|  |  |  |  |  |  | / | / |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ( |  | ) |  |  |  |  |  |  |
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| Email Address: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Cell Phone No. |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ( |  | ) |  |  |  |  |  |  |
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| Occupation |  | Employer |  |  |  |  |  | Employer Address |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Work Phone No. |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ( |  | ) |  |  |  |  |  |  |
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| Is this client covered by |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| insurance? |  |  |  |  |  |  Yes |  No |  |  | Is this an EAP visit? |  |  Yes |  |  No |  | Total Annual EAPs allowed? \_\_\_\_\_\_\_ |  |
|  |  |  |  |  |  |  |  |  Amerigroup  Assurant |  Beech Street |  |  Blue Cross/Blue Sheild |  ChoiceCare |  |  Champus |  |
| **Please Select Your** |  |  |  |  Cigna  Definity Health |  First Health |  |  HealthSmart  Humana |  Magellan/Aetna |  Medicaid |  |
| **Primary Insurance** |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Provider** |  |  |  |  Medicare  MHN/MHNet |  PHCS |  |  PMHS |  |  Texas One Choice |  TriCare |  Unicare |  |
|  |  |  |  |  |  |  |  |  United Healthcare |  Value Options |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| What is the authorization number? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  Self Pay |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Insured’s Name |  |  |  |  |  | Insured’s S.S. # |  |  | Birth Date |  |  | Group # |  |  |  |  |  |  |  |  |  | Policy # |  |  |  | Co-Payment |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | / | / |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | $ |  |  |
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| 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 |  |  |  |  |  |  |  |  |  |  |  |
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| **IN CASE OF EMERGENCY** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name of Local Friend or Relative (not living at same address) |  | Relationship to Client |  |  |  | Home Phone No. | Work Phone No. |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.**

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