**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: | | | | | | | | | | | | |  |  |  |  |  |  |  |
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| **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 | | | | | | |  |  |  |  |  |  |  |  |  |  |  |
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| 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 | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |
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| 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