Stopping the Chase Counseling

Intake Form

PLEASE PRINT CLEARLY Today's Date

PERSONAL INFORMATION

PATIENT (S)

Date of Birth Gender

Address

City, State Zip

Home Phone

Work Phone

Cell Phone

RESPONSIBLE PARTY

Address (if different)

City, State Zip

Home Phone (if different)

Work Phone (if different)

Cell Phone (if different)

Please indicate with an * which phone numbers we may NOT leave a message.

Patients' relationship to Responsible Party (check one): Self_______ Spouse_______ Child_______ Other _______

Relative or friend in case of emergency

Name Phone # Relationship

Name Phone # Relationship

Source of referral Reason for referral

Are you attending therapy for mandated reasons such as disability, court or custody issues? If yes please explain briefly.
____

How did you hear about Stopping the Chase Counseling? ____

FINANCIAL

I understand that Stopping the Chase Counseling and Consulting does not accept insurance. I will be given a receipt (super bill) that I may submit to my insurance for possible reimbursement. As well, I understand that if I cancel within 24 hours or do not show up for an appointment I will be billed the full amount of the session. I have been given the opportunity to ask questions regarding this statement.

____________________________________ ________________________________ _________________________

Signature of Responsible Party Printed Name Date

OVER

Therapist Use Only **Location** **Billing**

Therapist Name Memphis Client Self Pay

Dx

Special Instructions EAP – Bill EAP Company ____________________

# of Approved Visits ____________