Chester Community Clinic
Widener University

Client Intake Form

Name:_____ Today's Date:_____

Date of Birth: _____ Age:_____

Address:_____ City, State, Zip:_____

Phone:_____ Email:_____

Name of Referring Physician:_____

Emergency Contact:_____ Phone:_____

Employed? YES NO Occupation/Employer:_____

Do you drive? YES NO How did you hear about us?_____

Do you have Health Insurance? YES NO Insurance Co:_____

- If YES, why are you accessing pro bono services?

____Copays are too high ____Exhausted Insurance ____Other

Are you willing/able to donate $5.00/visit? YES NOT AT THIS TIME *(no penalty)*

This section is optional to complete:

Which of the following do you consider yourself? Check all that apply.

____Asian ____Hispanic/Latino ____White ____Other

____Pacific Islander ____Black/African American ____American Indian/Alaskan Native

Sex at birth: MALE FEMALE Gender Identity:_____

Please initial the following statements:

____**Notice of Client Rights & Responsibilities:** I acknowledge that I have received and read a copy of the Client Rights and Responsibilities form.

____**Notice of Privacy Practices**: I acknowledge that I have received and read a copy of the Notice of Privacy Practices that describes my rights regarding my health information and how my health information may be used or disclosed.

____**Authorization to Release Medical Information**: I authorize the Chester Community Clinic to release my medical information to my referring physician or nurse practitioner in order to coordinate care.

____**Consent to Treat**: I give my consent to the Chester Community Clinic students and licensed supervisors to provide outpatient therapy services considered necessary and proper for my diagnosis. I understand that I may refuse treatment at any time.

My initials above and my signature below indicate consent to all of the above.

Signature: _____ Date:_____