



CLIENT INTAKE FORM

Client Name

_____ /_____/_____
Last First Middle Date of Birth

Address

Street # City State Zip

I give permission to Southeast CFG to leave messages at the following phone numbers:

Home # (____) _____ Cell # (____) _____

I give permission to Southeast CFG to communicate via unsecured email using the following email address:

REFERRED TO SOUTHEAST CHILD & FAMILY GUIDANCE BY:

Dr. ___ Insurance Plan ___ Website ___ Family ___

Friend ___ Building is Close to Home/Work ___

Other ___ Please Specify: _____

_____ Please check here if you would like to be added to our email list for notification of upcoming therapeutic/wellness groups and events at Southeast Child & Family Guidance.

I hereby acknowledge that I have received or have been given access to a copy of the Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 919-855-3000.

I hereby authorize the release of necessary medical information for insurance reimbursement purposes, and authorize payment of medical benefits in Southeast Child and Family Guidance.

Client/Guardian Signature

Date