

Lauren Early, MA, LPCC
LEarlyCounseling@gmail.com

New Client Intake Form

Client Name _____ Today's Date _____

Social Security # _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Marital S M D W Gender _____ Employment Status _____

Employer _____

Were you referred? If so by whom? _____

Mobile phone: _____ Messages: Okay Voicemail No Messages

Home phone: _____ Messages: Okay Voicemail No Messages

How would you like to be reminded of appointments? Email or Text?

Email: _____

I would like to receive any billing/invoicing via email at the address listed below

SPOUSE/ SIGNIFICANT OTHER/ OTHER PARENT INFORMATION:

Name _____

Birthdate _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

PLEASE PROVIDE INSURANCE INFORMATION FOR BILLING PURPOSES

PRIMARY INSURANCE

Insured Name _____ Birthdate _____

Relationship to Client _____ Insured's SSN _____

Insurance Co. _____ Employer _____

Group # _____ ID# _____ Copay \$ _____

Is pre-authorization required? _____ PA# _____

SECONDARY INSURANCE

Insured Name _____ Birthdate _____

Relationship to Client _____ Insured's SSN _____

Insurance Co. _____ Employer _____

Group # _____ ID# _____ Copay \$ _____

Is pre-authorization required? _____ PA# _____

EMERGENCY CONTACT

Name _____ Phone _____

Relationship _____

Keeping a Card on File

Credit Card Information (Please complete information if you prefer to use a credit card, by completing and signing you are agreeing for Lauren Early, LPCC to bill this card for services provided).

Type of Card _____ Card Number _____

Name on Card _____ Expiration Date _____

Billing Address _____

CVV Code (3 digits on back) _____ Phone _____

Signature _____ Date _____

Zip Code _____

Would you like Lauren Early to keep your credit card information on file via Square? ____

INFORMED CONSENT AND NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Please initial at each point and sign to give your consent and permission

_____ By initialing, Client(s) acknowledge Client(s) have reviewed and fully understand the terms and conditions of this Agreement. Client(s) have discussed such terms and conditions with the therapist, and have had any questions with regard to its terms and conditions answered to Client(s)' satisfaction. Client(s) agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the Therapist. Moreover, Client(s) agree to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____ I hereby authorize my therapist to bill my insurance carrier or any other payment source. I assign all benefits and authorize payment directly to my therapist for any benefits otherwise payable to me for all claims for such services provided or submitted prior to, or after, the date provided on this form.

_____ I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges not paid for or denied by my insurance carrier. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my therapist to collect money on my behalf.

Name of Responsible Party (Please Print)	Signature of Responsible Party	Date
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I hereby acknowledge that I have been given an opportunity to read a copy of Lauren Early, LPCC's Notice of Policy & Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lauren Early, LPCC at 270-925-1455 or LEarlyCounseling@gmail.com.

Signature of Client	Date
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Signature of Client	Date
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*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)