Davis Mental Health Counseling Services, LLC **Marie A. Davis, LMHC, NCC**

Client Intake Information Sheet

Name: _____ **Sex:** M F **Date:** _____

Social Security #: _____ **Date of Birth**: _____ **Age:** _____

Marital Status: Single Married Divorced Widowed Separated In a Relationship Co-habitating

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Work:** _____ **Cell:** _____

Spouse/Partner Name: _____ **Phone:** _____

Which phone number would you prefer us to use to contact you if necessary? _____

Can we send you educational information by mail or e-mail? Y N **E-mail Address:** _____

Employer: _____ **Occupation:** _____

Name of Insured: _____ **Date of Birth:** _____

Insured's Employer: _____ **Insured's S. S. #:** _____

Insurance Company: _____ **Mental Health Benefits?** _____

Phone (for Mental Health Benefits): _____

Policy #: _____ **Plan/Group #:** _____

Primary Physician: _____ **Phone:** _____

Who may we thank for your referral? _____

Emergency Contact: _____ **Phone:** _____

I understand that I am responsible for payment in full at the time of the service, for all fees and Co-payments and that if I cancel an appointment without 24 hours notice or fail to attend a scheduled appointment, I am responsible for payment of that session.

_____ _____

Client Signature/ Date **Parent/ Guardian (if client is a minor)/ Date**

_____ I am initialing that I have fully read and understand the Client Service Agreement, Notice of Privacy Practices and Patient Bill of Rights. I have asked any questions regarding these documents. This informs me that copies are available upon my request. I also understand that there is a charge for not showing to scheduled appointments or not canceling an appointment with 24 business hours notice.