# Real Solutions Counseling

# *INTAKE INFORMATION SHEET*

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| **Caller’s Name:** | Relationship to Client:       |
| **Patient Name:** | **[ ] Male** **[ ] Female**  |
| **Telephone Number:** | **DOB:** |
| **Address:**  | **Age:** |
| If the client is under 18 (minor) Social Security Number for ICANS:      Parent or Guardian Name?      Alternative Number:       |
| **Email address for Correspondence:**  |
|  |
| Brief explanation of why you would like to come in?        |
| **Are you on any kind of medication? If yes, what and how much?** |
|  |
| **Do you have insurance?** **[ ] Yes** **[ ] No (If Medicaid jump down below)** |
| **Insurance Company:** | **Insurance Phone Number:**  |
| **Primary Insured’s Name:**  | Primary Insured’s DOB:       |
| **Insurance ID#:** | **Group#:** |
| **Telephone Phone number for benefits on your Insurance card:**  |
| Employer:       | **Employee Assistant Program? [ ] Yes [ ] No**  |
| **Auth#:**  | No of Visits:       |
| **Do you have Medicaid?** **[ ] Yes** **[ ] No Medicaid ID#:** **Primary Doctor?       Do you have the physical card? If not replacement #: 1-866-726-2237** |
| Have you had counseling in the last year: [ ] Yes Where at:      How did you hear about us?       |
| **Would you prefer mornings, afternoons, or evenings? [ ] Morning [ ] Afternoon [ ] Evening** |
| **Is there a day of the week that works best for you?** |
| I, as a Client or Insured Family Member, give consent and acknowledgement that this and other client information will be released to Insurance Carriers or Medicaid Agencies that provide financial reimbursement for requested services at Real Solutions Counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client/Parent/Guardian Signature) (Date) |