Office Use Only

Provider: ______________________

Appt Date/Time: _______________

Therapy Intake Form

To help us better understand your concerns, please complete the following information. **All of information provided is confidential.**

Client's Legal Name: _____________________ Preferred Pronoun: _______________________

Address: ____________________________ Email: _____________________________________

City: _______________________________ State: _________ Zip: ____________________

Age: ________ DOB: __________ Form Completed by: _____________________________

Gender: M ___ F ___ TM ___ TF ___ Gender Non-Conforming ___

Race: American Indian/Alaska Native ___ White ___ Black/African American ___ Other ___

Asian ___ Native Hawaiian/Pacific Islander ___ Two or More Races ___

Unknown ___ Declined ___

Mobile Phone: ____________ Home: ____________ Work: ____________ Other: ___________

Main reason(s) you are seeking therapy today: _______________________________________

____

____

Interested in Teletehrapy: Yes ____ No ____ Not sure ____

For Minor Clients

Mother's Name: ________________ Father's Name: _______________

Parents Marital Status: Married ____ Divorced ____ Separated ____ Single ____ Cohabitating ___

Both Aware Treatment has been Requested? ________

Health Insurance: If you expect insurance to reimburse you and/or Max Taylor, Psy.D., LLC for payment, please complete the following information below.

Primary Insurance: __________________ **Policy Holder:** ______________________________

DOB: __________ **ID#:** ___________________________ **Group#:** ______________________

Called Insurance Company for Authorization? Yes ____ No ____ Not Required ____

Secondary Insurance: ________________ **Policy Holder:** ________________________

DOB: _________ **ID#:** _______________________ **Group#:** ___________________

Called Insurance Company for Authorization? Yes ____ No ____ Not Required ____

The cost of health care and insurance benefits continues to rise, has become more complex, and can just be confusing. Today, managed health care (insurance companies) more often than not require pre-authorization before they will provide individuals reimbursement for mental health services.

Additionally, most insurance companies require the provider (me) to release information deemed relevant to the services provided such as dates of service, diagnosis, type and place of service, and possible other related confidential information. As most insurance companies make efforts to keep this information confidential, I am unable to control this shared information once in their possession. The client and/or responsibility party should be made aware that there could be potential legal and social risks that may or may not arise by the release of confidential information to their insurance company.

By signing this agreement, you are giving consent to release any relevant information to my insurance provider.

Client Signature/Representative: ____________________________Date: _______________

Name of Client (Print) ____________________________________Date: _______________

Representative Relationship to Client: ____

Thank you in advance for taking the time to provide the above information!