Lisa Rector, LCSW

Counseling and Psychotherapy

Client Intake Form

4505 S. Wasatch Blvd., Suite 190
Salt Lake City, Utah

Phone: (801) 870-4812
Email: lisarectorlcsw@gmail.com
Website: lisarectorlcsw.com

TODAY'S DATE: _______/_______/_______

CLIENT INFORMATION

CLIENT'S LAST NAME	FIRST	MIDDLE	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other	MARITAL STATUS Single / Married / Other
IS THIS YOUR LEGAL NAME? ☐ YES ☐ NO	IF NOT, WHAT IS YOUR LEGAL NAME?		BIRTH DATE ____/____/_____	AGE
STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER
EMAIL ADDRESS				
OCCUPATION	EMPLOYER			WORK PHONE NUMBER

REFERRED BY:

☐ THERAPIST ☐ DOCTOR ☐ FRIEND ☐ FAMILY ☐ WEBSITE ☐ OTHER (PLEASE SPECIFY) ______________

INSURANCE INFORMATION (IF YOU HAVE INSURANCE THAT WILL COVER YOUR THERAPY)

INSURANCE POLICY HOLDER NAME		POLICY HOLDER BIRTH DATE ____/____/____
INSURANCE PROVIDER	POLICY NUMBER	GROUP NUMBER
SECONDARY INSURANCE POLICY HOLDER NAME		SECONDARY POLICY HOLDER BIRTH DATE ____/____/____
SECONDARY INSURANCE PROVIDER	SECONDARY POLICY NUMBER	SECONDARY GROUP NUMBER

IN CASE OF EMERGENCY

EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE NUMBER

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

CLIENT NAME

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes and authorize the payment of medical benefits to the provider of services.

CLIENT/GUARDIAN SIGNATURE DATE