

INTAKE PACKET

Client Name: _____

Today's Date: _____

Insurance Name: _____ Policy #: _____

SSN: _____

IDENTIFYING INFORMATION

Home Address: _____ County: _____

Home Phone: _____ School/Grade: _____

Legal Guardian Name/Phone: _____

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

EMERGENCY CONTACT

First Contact: _____ Relationship to Client: _____

Daytime Phone: _____ Evening Phone: _____ Cell: _____

Physician's Name/Phone: _____

Others in the Home (Names/Relationship to Client/Ages if appropriate): _____

Significant Others Involved with Client: _____

MENTAL HEALTH/BEHAVIORAL INFORMATION

Reason for Seeking Services: _____

Recent Treatment History (last 12 months): _____

Pertinent Medical Issues: _____

Client Medications: _____

Other Active Service Providers (last six months): _____

Court Involvement and/or Pending Charges: _____

CONSENTS/RIGHTS INFORMATION

I. Consent for Treatment

I hereby give my consent for **Dr. Carol Bunch** to provide mental health services to me/my child. I have been informed of the scope and purpose of the service, and understand that I may withdraw my consent at any time. I understand I may also refuse any services offered at any time.

Client/Parent/Guardian: _____ Date: _____

II. Financial Release

I understand that **Dr. Carol Bunch** may use confidential information about me to bill and be paid for services. I hereby consent for **Dr. Carol Bunch** to release information to the billing agent, **Integrity Support Services** and its contracted clearinghouse, and/or to the funding source, and for the funding source to release information to **Dr. Carol Bunch** for this purpose.

Client/Parent/Guardian: _____ Date: _____

III. Permission to Transport

I hereby grant permission for **Dr. Carol Bunch**, to provide transportation to my child, and agree to hold **Dr. Carol Bunch** harmless for any accident/injury that results from the provision of transportation.

Client/Parent/Guardian: _____ Date: _____

IV. Permission to Seek Emergency Medical Care

I hereby give consent for **Dr. Carol Bunch**, to seek and sign consent for emergency medical care in the event that I am unable to do so for myself. It is understood that **Dr. Carol Bunch** will attempt to locate me, or another legally responsible adult, as quickly as is possible in the emergency situation.

Client/Parent/Guardian: _____ Date: _____

V. Client Rights/Grievance Policies (See Handout)

I have received and had explained to me the Client Rights handout. **Dr. Carol Bunch** gave me this handout and verbally explained my rights as a client.

Client/Parent/Guardian: _____ Date: _____

VI. Privacy Rights (See Handout)

I have received and had explained to me the Privacy Rights handout. **Dr. Carol Bunch** gave me this handout and verbally explained my rights concerning the privacy of information as a client. I understand these rights are designed to protect my privacy.

Client/Parent/Guardian: _____ Date: _____

I understand that one of my rights is to be able to choose how I am contacted.

I *do/do not* (please circle one) give permission for **Dr. Carol Bunch** to contact me at work.

Furthermore, I *do/do not* (please circle one) give permission for **Dr. Carol Bunch** to leave voice messages for me at *home/work/both/neither* (please circle one).

Client/Parent/Guardian: _____ Date: _____

I, **Dr. Carol Bunch**, have explained and provided copies of the following: Client Rights/Grievance Procedure Handout; the Privacy Rights Handout; and the Service Description to the Client/Parent/Guardian of the client to be served.

Signature: _____ Date: _____