**Robyn Coughlin, LCSW**
8690 Aero Drive
STE: 115-219
San Diego, CA 92123
619-997-5310

# CLIENT INTAKE FORM

*(Please bring completed form to your first appointment)*

**Today's Date** _____/_____/_____ **Therapist:** *Robyn Coughlin, LCSW*

## CLIENT INFORMATION

| *Client's Last Name* *First* *Middle* | ❑ *Mr.* ❑ *Ms.* | *Marital Status (Circle One)* *Single / Married / Other* |
|---|---|---|

| *Is this your legal name?* ❑ *Yes* ❑ *No* | *If not, what is your legal name?* | *(Former Name)* | *Birth Date* / / | *Age* | *Sex* ❑ *M* ❑ *F* |
|---|---|---|---|---|---|

| *Street Address* *City* *State* *ZIP Code* | *Social Security* - - | *Home Phone No.* ( ) |
|---|---|---|
| *P.O. Box* *City* *State* *ZIP Code* | | *Cell Phone No.* ( ) |

| *Occupation* | *Employer* | *Work Phone No.* ( ) |
|---|---|---|

*Referred to Provider by (Please check one box & list)* ❑ *Dr.* ____________ ❑ *Insurance Plan* ❑ *Website*
❑ *Family* ❑ *Friend* ❑ *Close to Home/Work* ❑ *Yellow Pages* ❑ *Other* ____________

| *Email Address:* | *Alternative Email Address:* |
|---|---|

## INSURANCE INFORMATION (PLEASE FILL OUT FOR INDIVIDUAL THERAPY CLIENTS ONLY)

| *Person Responsible for Bill* | *Birth Date* / / | *Address (if different)* | *Home Phone No.* ( ) |
|---|---|---|---|
| *Email Address:* | | | *Cell Phone No.* ( ) |

| *Occupation* | *Employer* | *Employer Address* | *Work Phone No.* ( ) |
|---|---|---|---|

| **Please Select Your Primary Insurance Provider** | ❑ *Aetna* ❑ *Humana* ❑ *MHN* ❑ *Cigna* ❑ *Prime* ❑ *Other* ____________ | ❑ *Cash Pay Only* |
|---|---|---|

| **Insured's Name** | | **Birth Date** / / | **Group #** | **Policy #** | *Co-Payment* $ |
|---|---|---|---|---|---|

**Client's Relationship to Insured** ❑ *Self* ❑ *Spouse* ❑ *Child* ❑ *Other* ____________

| *Name of Secondary Insurance (if any)* *Insured's Name* | *Group #* | *Policy #* |
|---|---|---|

*Client's Relationship to Insured* ❑ *Self* ❑ *Spouse* ❑ *Child* ❑ *Other* ____________

## IN CASE OF EMERGENCY

| *Name of Local Friend or Relative (not living at same address)* | *Relationship to Client* | *Home/Cell Number.* | *Email Address.* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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## PLEASE READ THE FOLLOWING 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. ______________________________ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.**

X ____________________________________________

CLIENT/GUARDIAN SIGNATURE DATE

**I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.**

X ____________________________________________

CLIENT/GUARDIAN SIGNATURE DATE

**I hereby authorize the release of necessary medical information for insurance reimbursement purposes.**

X ____________________________________________

CLIENT/GUARDIAN SIGNATURE DATE

**I authorize the payment of medical benefits to the provider of services.**

X ____________________________________________

CLIENT/GUARDIAN SIGNATURE DATE

**I understand that I am responsible for the full payment of fees should I not cancel my appointment within 24 hours.**

X ____________________________________________

CLIENT/GUARDIAN SIGNATURE DATE