Counseling Center For Emotional Growth

Patient Intake Form

Patient:

Last name:_____First name:_____ Date of Birth:_____

Address:_____City:_____ St.:____Zip:____

Telephone: _____ Email: _____

Insured Party:

Last name:_____First name:_____ Date of Birth:_____

Address:_____City:_____ St.:____Zip:____

Telephone: _____ Email: _____

Insurance Company: _____ ID no._____

Group no. _____

PLEASE PRESENT INSURANCE CARD AT THE FIRST SESSION / OR SUPPLY A COPY OF BOTH SIDES

Authorization to pay benefits to provider:

I hereby authorize payment directly to Counseling Center For Emotional Growth

_____ Sign by patient, insured part / guardian. Date:_____

Office use only: Procedural code_____ Diag. code:_____

Date of first visit: _____