Warren Street Family Counseling Associates, Inc.

INTAKE/REFERRAL FORM

Date: ____________________ Client Acct. # ________________

Referred by: ________________________________ Referred to: ________________

Caller Name: ________________________________ Relationship To Client: _________________________

First Appointment: Date: ____________________ Time: _____________________

PATIENT INFORMATION

Name: ____ DOB: ______/______/______ Gender: _____

Home Address: ____

Email : ____

Social Security #: _______-_______-_______ Employer: ____

Phone #: Home: _______-_______-_______ Cell: _______-_______-_______ Work:_____-_____-____

If Minor: Guardian #1 Address: ____

Phone Home: _______-_______-_______ Cell: _______-_______-_______ Work:_____-_____-_____

Email:____

Guardian #2 Address: ____

Phone Home: _______-_______-_______ Cell: _______-_______-_______ Work:_____-_____-_____

Email:____

Emergency Contact: Name __________________________________ Phone #: _______-_______-_______

Pervious Therapy: Y N With Whom: ______________________________ Last Seen: _______________

Type of Services Requested: Individual Couples Family Other ___________________________

Reason for requesting services: ____

MAY BE COMPLETED BY CLIENT OR CLINICIAN

Insurance Company: #1 ______________________________#2_____________________________________

Member #: ____#______________________________________

Co-Pay: $____________________________________ Deductible: $_________________________________

Self-Pay Fee: $________________________________

AUTHORIZATION TO TREAT MINORS (If Applicable)

☐ This is a referral from the Division for Children, Youth, and Families (DCYF)

☐ This is not a referral from the Division for Children, Youth, and Families (DCYF)

SOURCE OF CONSENT

☐ Parent ______________________________ Date: ____________________

☐ Legal Guardian ______________________________ Date: ____________________
(attach a copy of guardianship documentation)

☐ Court Order ______________________________ Date: ____________________
(Court Order number - please attach a copy)

OUTPATIENT SERVICES CONTRACT & HIPAA NOTICE FORM

I have read and discussed the Warren Street Family Counseling Outpatient Services Contract with my therapist. My signature below indicates that I agree to abide by its terms in my professional relationship with WSFCA. My signature also serves as an acknowledgement that I have received the HIPAA Notice Form. I am also aware and agree that I may be billed $______ for a missed appointment or inadequate notice.

initial _________

EMAIL AND CELL PHONE CONTACT

I understand that email and cell phone contact is not always private. If I have written or given my cell phone number or email address then my signature below gives permission for the therapist to use this method of contact.

initial _________

FINANCIAL RESPONSIBILTY STATEMENT

I understand that I am responsible for charges incurred that are not covered by my insurance. I understand that I am responsible for understanding my coverage and for knowing when the limits of my coverage are being exceeded. I understand that I am responsible for obtaining prior authorization for services from my insurance company if they require prior authorization. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to Warren Street Family Counseling. A copy of this signature is as valid as the original.

initial _________

______________________	______________________
Client Signature	*Parent/Guardian Signature*
______________________	______________________
Date	*Therapist*