Warren Street Family Counseling Associates, Inc.

INTAKE/REFERRAL FORM

Date: _____ Client Acct. # _____

CLIENT INFORMATION

Name: _____ DOB: ____/____/____

Gender: _____ Preferred Pronouns: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Social Security #: _____-_____-_____ Employer: _____

Phone #: Home: _____ Cell: _____ Work: _____

Emergency Contact: Name: _____ Phone #: _____

If Client is a Minor:

Guardian #1 Name: _____ Relationship to Client: _____

Address: _____

Phone #: Home: _____ Cell: _____ Work: _____

Email: _____

Guardian #2 Name: _____ Relationship to Client: _____

Address: _____

Phone #: Home: _____ Cell: _____ Work: _____

Email: _____

Previous Therapy: Y ☐ N ☐ With Whom: _____ Last Seen: _____

Type of Services Requested: Individual ☐ Couples ☐ Family ☐ Other ☐ _____

Reason for requesting services: _____

PAYMENT METHOD INFORMATION

I plan to use the following payment method for my services:

☐ Insurance

☐ Self-Pay: $_____ per session (rate as stated by my clinician)

E-STATEMENTS

I understand that WSFCA uses electronic statements.

Please use this E-mail address for E-statements: _____

APPOINTMENT REMINDERS

I would like appointment reminders via:

☐ Text_____ ☐ Call _____ ☐ Email _____

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*