Labyrinth Counseling & Consulting Center

1770 Park St., Suite 109, Naperville, IL 60563 Phone: 630.305.5702

NEW CLIENT INTAKE FORM

ATTENTION: PLEASE COMPLETE THIS FORM IN BLUE OR BLACK INK AND PRINT NEATLY

Name of Therapist you are seeing today:_____ Today's Date:_____

CLIENT INFORMATION:

Full Name:_____ Date of Birth:_____ Male ☐ Female ☐

Address:_____ City, State, Zip:_____

Home phone ( )_____ Employer/work ( )_____

Cell phone ( )_____ Driver's License #: _____

E-Mail Address: _____

( ) Single ( ) Married ( ) Living with Partner ( ) Divorced ( ) Survived Partner

If a minor (under age 18), please write name of legal guardian: _____

Are bills to be sent to the above address? Yes ☐ No ☐; If "No," please fill out information below:

PARTY RESPONSIBLE FOR PAYMENT:

Name:_____ Date of Birth: _____

Address:_____ City, State, Zip:_____

Home phone ( )_____ Cell phone ( )_____

INSURANCE SECTION:

Group Name/Number: _____ Identification Number: _____

Insurance Company Name:_____

Insurance Company Phone:_____

Claims Mailing Address:_____

Scriber Name:_____ Subscriber Date of Birth: _____

Relationship to Client: _____

Insurance Authorization Info/Notes (Office use Only):

CLIENT MEDICAL INFORMATION:

Health Problems:_____

Physician Name and Phone Number: _____

Current Medications and dosages: _____

_____

PLEASE READ AND SIGN THE FOLLOWING AGREEMENT.
DO NOT SIGN UNLESS IT IS CLEAR TO YOU.

By signing below, I am requesting services from Labyrinth Counseling Center. I also understand that Labyrinth Counseling Center therapists will discuss my case, or my child's case, within the center for consultation and supervisory purposes and/or outside the center for educational and supervisory purposes. In addition, by signing this I give permission for Labyrinth Counseling Center to use my art work for educational and supervisory purposes.

Signature _____ Date _____

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OFFICE USE—ALL OF THE FOLLOWING IS TO BE COMPLETED BY THE THERAPIST

Diagnosis Code: Session Fee:

If CLIENT has **BC/BS** insurance, please provide: Date of Current Illness/Injury: _____

Same or Similar Illness—first date: _____

Billing Instructions from Therapist: ***Please circle as applicable***

Please file with insurance company Client will handle insurance if any Client is self-paying

FOR MINOR CLIENTS (under the age of 18)

If Client is a Minor and Parents are Legally Married, please sign below:

I authorize Labyrinth Counseling Center to provide Mental Helath Services to my child,_____

_____. I am the legal guardian of this child. I understand that by signing this I am

aknowledging that my spouse is also in agreement and has knowledge of the services that will be provided.

Signature _____ Date _____

If Client is a Minor and Parent has Joint Custody, please sign below:

I authorize Labyrinth Counseling Center to provide Mental Helath Services to my child, _____

_____. *Both parents' signatures are required before treatment can occur.*

Mother Signature _____ Date _____

Father Signature _____ Date _____

If Client is a Minor and Parent has Sole Custody, please sign below:

I authorize Labyrinth Counseling Center to provide Mental Helath Services to my child, _____

_____. By signing this, I state that I am the legal guardian of said child with sole

custody.

Signature _____ Date_____