

# 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: \_\_\_\_\_

My Gender is: \_\_\_\_\_ My Pronouns are: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Employer/work ( ) \_\_\_\_\_

Cell phone ( ) \_\_\_\_\_ Driver's License #: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

( ) Single ( ) Married ( ) Partnered ( ) Divorced ( ) Survived Partner/Spouse

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: \_\_\_\_\_

Subscriber 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 & Consulting Center. I also understand that the Center’s psychotherapists 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 & Consulting 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 & Consulting Center to provide Mental Health Services to my child,  
\_\_\_\_\_. I am the legal guardian of this child. I understand that by signing  
this I am acknowledging 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 & Consulting Center to provide Mental Health 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 & Consulting Center to provide Mental Health Services to my child,  
\_\_\_\_\_. By signing this, I state that I am the legal  
guardian of said child with sole custody.

Signature \_\_\_\_\_ Date \_\_\_\_\_