

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 _____

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 _____