Jennifer Stowell, LPC

Patient Intake Form

Name: Last: _____ First: _____ Middle Initial: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home telephone: _____ Cell: _____

Employer: _____ Work phone: _____ Extension: ____

Gender: _____ Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Relationship Status: _____ May I leave messages at your home or phone? Yes ___ No ___

Emergency Contact: _____ Phone: _____

Referred by: _____ Primary Physician: _____ Phone: _____

Do you have any special confidentiality requests? _____

_____

Insurance Information

Primary Insurance: _____ ID# _____ Group #: _____

Policy Holder's Name: _____ SSN: _____-_____-_____ Date of Birth: _____

Secondary Insurance: _____ ID# _____ Group #: _____

Policy Holder's Name: _____ SSN: _____-_____-_____ Date of Birth: _____

If you are using your Employee Assistance Program (EAP) please complete the following:

EAP Name: _____ Authorization #: _____ Number of Sessions: _____

My permission is granted to allow my insurance carrier to make remittance on my behalf directly to Jennifer M. Stowell, LMHC. This assignment will remain in effect until removed by me in writing. I hereby authorize the release of all medical information necessary (including diagnosis) to secure payment from my insurance company.

Signature: _____ Date: _____

Office Use only

DX Code: _____ Description: _____

DX Code: _____ Description: _____

Insured Signature on File? Yes No

Special instructions for insurance claims: _____

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