Sue Moreland, MSW, LCSW
11415 NE 128th ST. Suite 100
Kirkland, WA 98034
425-820-7100

INTAKE FORM

Date: ________________

Name____________________________________(please include middle initial)

Mailing Address ____Zip_________

Residence address (if different)____

Telephone: Home_______________________ Work___________________________

Birthdate_______________________________SS#_____________________________

INSURANCE INFORMATION (if applies to mental health services)

This information is necessary for services to be billed for you.

Insurance Co. ____

Billing Address______________________________ PH: ________________________

Subscribers Name______________________________ Birth date ________________

Subscriber's SS#____________________________ Policy ID#____________________

Group # ___________ Subscriber's employer __________________________________

Co pay at time of visit______________________ Percentage of coverage____________

Deductible _________ Month deductible is renewed _______Currently met? _________

Emergency contact ______________________________PH: ______________________

Physician______________________________________ PH: ______________________

Current Medications____

Prescribed by__________________________________ PH: ______________________

Previous Therapist___________________________ Dates of Treatment_____________

Referred by____

Why are you seeking therapy at this time? _____________________________________

____

____

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Insurance Billing Authorization

Client Name_________________________________ SS#______________________

If a minor parent or guardian's name ____

(Please initial each paragraph. If a minor parent or guardian must initial)

_______ I authorize Sue Moreland, MSW, CSW (or her assistant) to bill my insurance company for services rendered by her for me.

_______ I authorize Sue Moreland MSW, CSW to receive payment from my insurance company directly.

_______ I understand Sue Moreland will discuss with me the nature and content of information released to my insurance company beyond diagnosis and type of service and that this will happen during my sessions.

_______ I will hold Sue Moreland harmless for any loss of confidentiality related to the release of information necessary process claims to my insurance company.

_______ I understand if my insurance company does not pay for services I will be responsible for payment for services unless Sue Moreland's contract with my insurance company prohibits billing the patient directly for claims not authorized.

______ I understand that I am responsible for the payment of the any deductibles, co pays or co insurance payments unless I am a minor. If I am a minor than my parent(s) or legal guardian(s) are responsible for these payments.

Signature_______________________________ Date________________________

Signature of parent or guardian _______________________________ Date _______

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I (client's printed name) ____

Authorize (therapist's printed name) ____

To give the following information:

____

____

____

To: (recipient's printed name): ____

I understand the purpose of sharing the above information will be____________________

____

____

I further understand that this confidential information is protected under state law, and that I may revoke this release form at any time by contacting the above named therapist directly. I also understand that the form will automatically expire 90 days from the date I sign it, or on the following date if less than 90 days.

Client(s)/Guardian Signature ____

____

Date: ______________________________

Date Release Expires (if less than 90 days)__________________________