

CLIENT DEMOGRAPHIC AND INTAKE FORM

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Client Name: _____

Client email address: _____

Client Home Phone: _____ Other : _____ Okay to leave messages? ___

Client Social Security Number: _____ Client Date of Birth: _____

Client Marital Status: _____ Favorite Color: _____

Client Address: _____

City/State/Zip: _____

Work Status: Employed: ___ Unemployed: ___ F/T Student: ___ P/T Student: ___ Work at Home: ___

Immediate Family Names and Ages (Children/Siblings/Parent/Spouse or Significant Other):

In Case of Emergency Notify: _____

Emergency Phone #: _____ Relationship to client: _____

How were you referred to me?

INSURANCE: If you would like me to file with your insurance, You Must Complete the Following, or you will be responsible for your visits. Be sure that a copy of your current insurance card has been attached to this document.

Have you called your insurance company to verify benefits and to request authorization? Yes ___ No ___

Authorization Number: _____ # Sessions: _____ Co-pay Amount: _____

Insurance Company or EAP Name: _____

Insurance Company or EAP Phone: _____

Insurance Company or EAP Billing Address: _____

ID# if different from *your* SSN: _____ Group # if any: _____

Primary Insured's Name: _____ Relationship to Client: _____

If client is *not* the Primary Insurance Holder:

Primary's Employer: _____

Primary's SSN: _____ Primary Insured's Date of Birth: _____

Primary's Address: _____

City/State/Zip: _____ Primary's Phone numbers: _____

Is the client covered by a secondary health insurance policy? Yes ___ No ___

If Yes, please request an additional form to complete this same information for that second company.

Signature: _____ Date: _____