130 Northwoods Blvd
Columbus, OH 43235
(833) 566-0318

Client Intake Form

Name (First and Last): _____ Date of Birth: _____

Age: _____

SS#: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone Number: Home: _____ Work: _____ Cell: _____

Email Address: _____

Employer Information

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Employer Phone Number: _____

Nearest Relative Information

Nearest Relative Name: _____

Nearest Relative Address: _____

City: _____ State: _____ Zip Code: _____

Nearest Relative Phone Number: _____

Relationship with Nearest Relative Name (i.e. brother, sister, mother, etc.): _____

Emergency Contact Information

Emergency Contact Name: _____

Emergency Contact Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Phone Number: _____

Relationship with Emergency Contact (i.e. brother, in-law, mother, etc.): _____

Insurance Information

Insurance Company Name: _____

Insurance Company Phone Number: _____

Insured's Name: _____

Insured's Date of Birth: _____

Insured's SSN Number: _____

Insured's Employer: _____

Insurance Policy ID Number: _____

Insurance Policy Group Number: _____

Effective Date of Policy: _____

Release of Information

I authorize Scott Colin Winter, LSW, to release/exchange treatment information with my family physician and health plan's utilization reviewers in order to facilitate my treatment with Scott Colin Winter.

Signature of Client, Parent, or Guardian: _____

Date: _____

Financial Responsibility

I understand that I am financially responsible for any balance or copay not covered by my insurance.

Signature of Client, Parent, or Guardian: _____

Date: _____

Payment Authorization

Insured's or Authorized person's signature: I authorize payment of benefits to the undersigned physician or supplier for services provided.

Signature: _____

Authorization for Client Appointment Information

I authorize the following individuals to (check all that apply):

- ☐ Schedule Appointments
- ☐ Cancel Appointments
- ☐ Change Appointments
- ☐ Inquire About Appointment Times/Dates
- ☐ Discuss/Handle Billing, Insurance, and Payment Issues

Name of Authorized Individual: _____

Relationship to Client: _____

Name of Authorized Individual: _____

Relationship to Client: _____

Name of Authorized Individual: _____

Relationship to Client: _____

I understand that no information other than what is indicated above will be shared with the individuals indicated on this form.

Signature of Client: _____

Signature of Parent or Guardian (If Applicable): _____

Date: _____

HIPAA Agreement

Your signature below means that you have read the enclosed HIPAA form provided and that you have asked questions if necessary, understand the form, and understand its implications.

Signature: _____

Additional Questioning

Reasons for engaging in therapy at this time:

What would you like to achieve by engaging in therapy at this time?

Have you received counseling in the past? If yes, please explain the type of counseling you received and what you found most helpful and least helpful.

Are you currently on any prescription medications? Please list medication, dosage, how long you have been taking the med(s), prescribing physician, and if you feel like it has been working.

Please write your current active doctors including primary care physician and specialists. Please include their phone numbers.

Treatment Agreement

Your signature below indicates your agreement to obtain treatment by Scott Colin Winter, LSW.

Signature: _____