Thomas Sterling, LCSW LCS#18845

CONFIDENTIAL CLIENT INTAKE FORM

Client's Full Name_____ Preferred Name: _____
Client's DOB: _____ Age: _____ SSN: _____
StreetAddress:_____
Apt/Suite #: _____City: _____ State: _____ Zip:_____

Home Phone: _____ Mobile Phone: _____
Work Phone: _____ Email Address: _____

I authorize Thomas Sterling, LCSW
☐ to leave messages at the phone (s) listed above.
☐ To Send email and/or text notices about appointments

Signature: _____

PRIMARY CARE PROVIDER

Physician's Name: _____ Office phone #:_____
Street address: _____
City: _____State: _____ Zip: _____

PSYCHIATRIST

Psychiatrist's Name: _____Office phone #:_____
Street address: _____
City: _____State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship:_____
Home Phone: _____ Cell Phone: _____

Billing and insurance Information:

Name of insured: _____

Primary Plan Name: _____ Insured ID #: _____

Effective Date: _____ Group # _____

Secondary Plan Name:_____ insured ID #: _____

Effective Date: _____ Group # _____

Plan Subscriber Employer: _____

Co-Pay Amount: $_____ Sliding Fee Amount: $_____

Assignment of benefits/ Agreement to pay

- I hereby assign payment of authorized Medicare or other insurance benefits and any other medical and/or surgical benefits, to include major medical benefits to which I am entitled, to be made either to me or on my behalf to Thomas Sterling, LCSW or any service furnised me by that phsysician/supplier. I authorize any holder of medical information about me to release any information needed to determine tese benefits payable for related services
- This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to relase information necessary to secure payment
- I authorize Thomas Sterling, LCSW to to release medical information about me that may be needed to submit and obtain payments from a working agreement payment source.
- I understand that I am responsible for payment of charges that are not covered by insurance or any other funding source. This includes charges for checks returned due to non-sufficient funds.

_____ _____

Client/Parent/Guardian/Guarantor Signature Date

_____

Relationship to client

_____ _____

Witness signature Date