Amy Urbanek, LPC, NCC

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Patient Intake Form

Name:_____ **Date:**_____
(First) (Last) (Middle Initial)

Name of parent/guardian (if under 18 years):_____
(First) (Last) (Middle Initial)

Birth Date: _____/_____/_____ **Age**:_____ **SSN:**_____

Gender:_____Male_____Female **Marital Status:**_____ **Race/Ethnicity**: _____

Highest Level of Education: _____ **Currently Employed?**____Yes_____No

Employer?_____

Street Address:_____

City:_____**State**:_____ **Zip:**_____May I send mail to this address?___Yes____No__

Primary Phone Number: _____**Type**:_____Home_____Cell_____Work

May I leave voicemail? Yes No Would you like to receive text appointment reminders on this number?____Yes ____No

Secondary Phone Number (optional):_____**Type:**_____Home_____Cell ____Work

Email address (Optional):_____**Type**: _____Personal email_____Work email

Would you like to be sent a link to Counselingkit.com to be able to use a secure client messaging service?___Yes ___No

Which of these methods do you prefer for contact?_____Phone _____Email _____Mail _____Any of these

Emergency Contact:_____ Phone:_____**Relationship:**_____

- Primary Insurance -

Insured's Name:_____Insured's SSN:_____ Insured's Birthdate: _____

Relationship to Patient:_____Insured Employed By:_____Insured's Phone: _____

Insured's Address, if different: _____

Insurance Company: _____Insurance Company's Phone: _____

Policy Number:_____Identification Number:_____Group Number:_____

Is patient covered by additional insurance? ___No____Yes- Insurance:_____(please provide copy of card)

- Assignment and Release -

I, the undersigned, certify that I or my dependent has insurance coverage with the above named insurance company, and I assign directly to Amy Urbanek, LPC, NCC, PLLC all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges, whether or not they are paid by my insurance. I hereby authorize Amy Urbanek, LPC, NCC, PLLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____ _____
Responsible Party's Signature Relationship to Patient Date

FOR OFFICE USE ONLY: Text? Y N E-mail? Y N Voicemail? Y N Consent to Release? Y N Copay: _____