Surviving Transitions, LLC
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Client Intake Information Form

PERSONAL INFORMATION	
Client First Name:	Client Last Name
Date of Birth:	Address:
SSN:	City, state, zip
Gender	Contact phone:
Employer:	Employer Address
Referred by:	Email:
May I have permission to thank the person who referred you: ☐ YES ☐ NO	

INSURANCE INFORMATION	
Policy Holder Name:	Policy Holder SSN:
Date of Birth:	Insurance Company:
SSN:	City, state, zip
Member ID:	Insurance Customer Service#:
Group Number:	Policy Holder employer:
Co-Pay $_____	Deductible? ☐ **Yes** ☐ **NO** **Deductible Amt:$_____**
Authorization required? ☐ **Yes** ☐ **NO**	Authorization #_____
# of sessions Authorized?_____	Max Amount of sessions allowed per year _____
Insurance Name:	Secondary Insurance Policy? ☐ **Yes** ☐ **NO**
Has any of your deductible been met as of yet? ☐ **Yes** ☐ **NO** **If so, how much? $_____**	

FOR OFFICE USE ONLY

COMMENTS/CONCERNS:

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