

POSITIVE PERSPECTIVES, INC.

ADULT INTAKE FORM

Date: _____ Referral Source: Insurance/Managed Care Referral Internet Search Phone Book
 Physician (Name) _____ Friend/Family Our Website Other: _____
 Professional Referral (e.g. the name of the referring therapist, attorney, pastor): _____

Client Name: (Last) _____ (First) _____ (M.I.) _____ Male Female
Prior Name(s): _____ Age: _____ Date of Birth: _____ Client SS# _____
Address: _____ City: _____ State: _____ Zip: _____
Home#: _____ Work#: _____ Additional#(s): _____

<u>Who else lives in your home?</u>	<u>Sex</u>	<u>Birth Date</u>	<u>Age</u>	<u>Relation to client</u>
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

(If more room is needed, please continue on reverse side)

Employed by _____ Occupation _____ Full-time? Part-time?
Are you a Student? Yes No Highest Grade or Degree Completed _____
Relationship Status: Married Single Living Together Separated Divorced Widowed
Physician _____ Office# _____ Reason for seeking service: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Client: _____
Home#: _____ Work#: _____ Additional#: _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Employer _____
Policyholder Name _____ SS# _____
Policy ID# _____ Group Code _____ Insured's Birth Date _____
Insured's address if different than Client: _____
Secondary Insurance Co. _____ Employer _____
Policyholder Name _____ SS# _____
Policy ID# _____ Group Code _____ Insured's Birth Date _____
Insured's address if different than Client: _____

AUTHORIZATION AND PERMISSION TO TREAT

I hereby grant authorization to Positive Perspectives, Inc. to release any Protected Health Information (except Psychotherapy Notes) to my insurance company that is necessary for billing, or to process my claim for payment of services. I authorize my insurance company to send payment directly to Positive Perspectives for all services provided. I also authorize Positive Perspectives to release claim forms and supporting documentation to the Ohio Department of Insurance if Positive Perspectives files a claim against my insurance company under the Ohio Prompt Payment Law. I agree that a photocopy of this authorization shall be as valid as the original.

I hereby consent for Positive Perspectives, Inc. to provide treatment and evaluation to _____.
(Name of Client or Self)

Signature _____ Relationship to Client _____ Date _____ Revised 1/24/08 CBL