Hope Renewed Counseling Center, LLC.
Lila A. Reid, MSW, LICSW

"Where the power of hope is realized"

INITIAL CLIENT INTAKE ASSESSMENT

Date: _____

Name_____
First MI Last

Address_____ Apt#_____ Cell#_____

City_____ State____ Zip_____ Telephone # (__)_____

D.O.B_____ Marital Status – **M/S/W/D** Religious preference_____

Referred By:_____ Physician: _____

Past Hospitalizations (date):_____

Any current or previous mental health providers: _____

_____

Any previous medical and/or psychiatric diagnosis:_____

_____

Current medications include:_____

_____

Presenting problem:_____

Pharmacy name: Pharmacy phone#_____

In the event of an emergency please contact:

Name: _____ Phone: _____ Relationship: _____

School Information:

School Name _____ Phone # _____ Grade _____

EMPLOYMENT INFORMATION:

Employment: - F - P/T - Retired - Not Employed - ***(circle one)***

Employer_____ Phone (_____)_____-_____

Address_____City_____ State____ Zip_____

INSURANCE INFORMATION:

Insurance Plan Name_____

Address_____City_____State Phone _____

Subscriber Name_____("Same" if same as client)

Subscriber Address_____("Same" if same as client)

Subscriber's Employer _____ Subscriber DOB_____

Subscriber ID#_____Group#_____Policy#_____

CLIENT or AUTHORIZED PERSON'S SIGNATURE REQUIREMENTS

PLEASE READ AND SIGN All SECTIONS

Release of Information

I (Client, parent or guardian) authorize the release of any medical or other information necessary to process insurance claims.

Signed_____ Date_____
(Client/authorized person)

Assignment of Benefits

I authorize payment of medical benefits to: Hope Renewed Counseling Center, LLC.

Signed_____ Date_____
(Client/authorized person)

Cancellation Policy

I request that you please give me at least 24 hours notice if you must cancel an appointment. If you must cancel on short notice for unavoidable reasons, please call to let me know that you are not coming. I charge my usual fee for unnecessary cancellations or missed appointments. Please be aware that insurance companies will not pay for canceled or missed appointments.
I have read and understand the cancellation policy.

Signed_____ Date_____
(Client/authorized person)