Karma Counseling

Zahra Payravian, LPC

Couple Intake Form

Today's Date / /

PATIENT INFORMATION (PRIMARY CONTACT)

Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Email Address:

SPOUSE / PARTNER INFORMATION

Name:	□ Mr. □ Ms.	Birth Date / /	Age	Sex

Phone No.:	Address (If Different):

Email address:

INSURANCE INFORMATION

Policy Holder Name	Birth Date / /	Address (If Different)	Home Phone No. ( )

Email Address:		Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Member ID No.	Group No.	

Please Select Your Primary Insurance Provider	❑ Blue Cross/Blue Shield ❑ Cigna ❑ Aetna ❑ Beacon ❑ Other

Will you be using EAP's (Therapy appts. only)? □ Yes □ No If yes, what company is the EAP through?	EAP Authorization # No. of sessions authorized

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same	Relationship to Client	Home Phone No.	Work Phone No.

HOW DID YOU HEAR ABOUT US?

□ Internet Search	□ Friend	□ Facebook	□ Advertisement
□ Another Doctor's Office Office/ Doctor's Name:			□ Other

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I agree to further honor contractual agreements made with Karma Counseling (Service Agreement and Office Policies) document and those with my managed health care companies, which stipulate specific reimbursement restrictions.

X

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment for myself or my child by the specified provider. Although the chances for obtaining my (his/her) goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment for my child or myself at any time. I understand that I am responsible, however, for any balance for services rendered.

X

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary Protected Health Information (PHI) for treatment and insurance reimbursement purposes.

X

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical and mental health benefits to Karma Counseling or the provider of services.

X

CLIENT/GUARDIAN SIGNATURE DATE