Casey A. Holtz, Ph.D., LLC.
126 N. Jefferson St., Suite 200
Milwaukee, WI 53202

Client Intake Form

I truly appreciate your choosing to come to me for psychological help. Please complete the below information for our files. We may contact you annually to update our files.

Date: _____

Name of Parent (s): _____

_____

Name of client: _____

Contact below is ❑ client ❑ spouse/partner of client ❑ parent ❑ legal guardian ❑ legal custodian

Usable phone number (day/eve/work/cell): _____ any limitations? _____

Usable email address: _____ any limitations? _____

Client's address: _____

_____

Your address (if different): _____

_____

Referral source ("How did you get my name?"):

_____

Primary reason for referral: _____

_____

Financial Information Form

As part of providing high-quality services, we need to be clear about our financial arrangements.

• If you have health insurance, it may pay for a part of the cost of your treatment here. To find out if this is so, I need the information requested below.

• If you are utilizing a service that is not billable for insurance (e.g., child specialist and mediation), or do not intend to use insurance, please check here ❑, complete all sections except C, and return this form to me.

A. Patient's name: _____ Birthdate: _____

Address: _____Home phone: _____

(If the patient is a dependent) Insured's/policy holder's name: _____

Insured's/policy holder's date of birth: _____ Insured's mailing address if different:

_____

B. (If applicable) Spouse's (or ex-spouse) name: _____Birthdate: _____

cell phone:_____ mailing address: _____

email address: _____

C. If you (or your spouse, or child) have any of these kinds of insurance, please fill in the numbers and names .

1. Name of insurance company:_____

Name of policyholder (if not the patient): _____

Policy #: _____ Certificate or group number #:_____

Phone: _____ Address to send claims: _____

D. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

E. I understand that I am responsible for all charges, regardless of insurance coverage.

F. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client's (or parent/guardian's) signature, indicating agreement to all of the statements above

Date

_____