

# Initial Intake Form

**Paul Roy, LCSW**

7500 W. Mississippi Ave., Suite A-115  
Lakewood, CO 80228

Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

State ID #: \_\_\_\_\_ (If required for insurance purposes)

Client Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Client Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Client Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: (Home) \_\_\_\_\_ OK to leave messages? Y: \_\_\_ / N: \_\_\_

(Cell) \_\_\_\_\_ OK to leave messages? Y: \_\_\_ / N: \_\_\_

(Work) \_\_\_\_\_ OK to leave messages? Y: \_\_\_ / N: \_\_\_

Email: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Referred by: \_\_\_\_\_

## In Case of Emergency Contact:

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Person Responsible for the Bill:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

### Insurance Information:

Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Group #: \_\_\_\_\_

Address for Claims: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Authorization #: \_\_\_\_\_

# of Sessions Authorized: \_\_\_\_\_

Co-pay: \_\_\_\_\_

Deductable: \_\_\_\_\_

Payment is expected at the beginning of each session. I am a participating provider with Anthem Blue cross Blue Shield, CIGNA, and Medicaid from Denver, Arapahoe, and Douglas Counties, and will accept co-payments and bill your insurance for reimbursement. Covered benefits are not a guarantee of payment to me and you will be responsible for any service denied by your plan. If you are planning to use any other type of insurance to pay for your services, I will assist you in determining coverage, benefits and eligibility, but you are expected to pay the full fee at the time of your visit and to file your own claims. Most insurance plans do not cover marital therapy or couples counseling, but I will be happy to provide you with an invoice for your own submission efforts.

My fee is \$120 per session and I accept cash, checks, or major credit cards. I offer a sliding fee for those with no insurance or limited income. I will discuss this on a case-by-case basis with each client in order to reach a mutual fee agreement. Clients are asked to give 24 hours advance notice when canceling an appointment. **I charge an \$80 cancelation fee to clients who cancel without notice**, and insurance companies will not cover these fees. Exceptions may apply for true emergencies.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_