

ADE, Inc
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CLIENT INTAKE FORM

(Please Print)

Today's Date ____/____/____

Therapist _____

CLIENT INFORMATION

Client's Last Name			First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Married / Other		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name)			Birth Date	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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. ()			
Referred to Provider by (Please check one box & list)					<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Website	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to Home/Work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other _____				
Email Address:					Alternative Email Address:			

INSURANCE INFORMATION

HOSPITALIZATION OR EMERGENCY PURPOSES ONLY

Person Responsible for Bill	Birth Date / /	Address (if different)			Home Phone No. ()		
Email Address:					Cell Phone No. ()		
Occupation	Employer	Employer Address			Work Phone No. ()		
Is this client covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this an EAP visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		Total Annual EAPs allowed? _____			
Please Select Your Primary Insurance Provider		<input type="checkbox"/> Amerigroup <input type="checkbox"/> Assurant <input type="checkbox"/> Beech Street <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> ChoiceCare <input type="checkbox"/> Champus <input type="checkbox"/> Cigna <input type="checkbox"/> Definity Health <input type="checkbox"/> First Health <input type="checkbox"/> HealthSmart <input type="checkbox"/> Humana <input type="checkbox"/> Magellan/Aetna <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> MHN/MHNet <input type="checkbox"/> PHCS <input type="checkbox"/> PMHS <input type="checkbox"/> Texas One Choice <input type="checkbox"/> TriCare <input type="checkbox"/> Unicare <input type="checkbox"/> United Healthcare <input type="checkbox"/> Value Options <input type="checkbox"/> Other _____					
		What is the authorization number?					<input type="checkbox"/> Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
Client's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance (if any)		Insured's Name		Group #	Policy #
Client's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

IN CASE OF EMERGENCY

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

ADE, Inc
CLIENT INTAKE FORM
(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 by the client. ADE, Inc does not accept any insurance plans and is a fee for service provider.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by Dr. Ireland. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for hospitalization and emergency purposes.

X _____
CLIENT/GUARDIAN SIGNATURE DATE