Client Intake Form

Phone: (703) 722-2324

ADE, Inc.
Dr. Martha H. Ireland
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Hardeeville, SC 29927

Email: info@irelandphd.com

(Please Print)

Today's Date _____/_____/_____ **Therapist_____________________________**

CLIENT INFORMATION

Client's Last Name	First	Middle	Preferred Pronouns ❑ he, him, his ❑ she, her, hers ❑ they, them, theirs	Gender Identity ❑ Man ❑ Non-Binary ❑ Woman

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Marital Status ❑ Single ❑ Other ❑ Married

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) ❑ Dr. __________ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ 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? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? ________

Please Select Your Primary Insurance Provider

❑ Amerigroup ❑ Assurant ❑ Beech Street ❑ Blue Cross/Blue Sheild ❑ ChoiceCare ❑ Champus
❑ Cigna ❑ Definity Health ❑ First Health ❑ HealthSmart ❑ Humana ❑ Magellan/Aetna ❑ Medicaid
❑ Medicare ❑ MHN/MHNet ❑ PHCS ❑ PMHS ❑ Texas One Choice ❑ TriCare ❑ Unicare
❑ United Healthcare ❑ Value Options ❑ Other ______________________________

What is the authorization number?	❑ Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ 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.

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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