Intake Form

Date of Contact:_____

Client:_____ **DOB:**_____

Phone:_____ **SS#**_____

Address: _____

_____

Email: _____

Sex: **M** **F**

Marital Status: **Married** **Single** **Other**

Employment: _____ **Student: FT PT**

Insurance and Payment for Service Agreement:

True North Counseling and Wellness will bill your primary and/or secondary health insurance company. Your insurance company provided the summary of possible benefits without knowledge of the diagnosis or treatment plan for services. All benefits are subject to pre-existing condition limitations as specified in the plan. You are responsible for making a payment at each session (if applicable) and are responsible for any balance remaining if and when your insurance company pays their portion. You will be responsible to ensure current insurance information and any required pre-authorizations by your insurance company are provided to TNC. Co-Pay amounts will be paid prior to service when applicable.

_____ _____

Signature **Date**

_____ _____

Witness - TNC **Date**