Intake Information Kim Gilliland, LMFT

Date: _____

Name(s): _____

Address(es): _____

_____

_____

Best phone number to reach you: _____

Emergency contact/partner's phone number: _____

Email address(es): _____

_____

Referral Source: _____

Private Pay? Rate: _____

Insurance Information

Carrier: _____

ID#: _____

Group #: _____

Plan Name: _____

Name and Date of Birth of Subscriber: _____

Name and Date of Birth of Patient (if not the Subscriber):

_____

Reasons for seeking counseling at this time: _____

_____

_____

_____

_____