Office Use Only
Pt. Account #: ____________
Intake Date: ____________
Dx: ____________
Dx: ____________
Therapist: ____________

Intake Form

Welcome to LMPRC. ***Please complete the following form.***
All information will be kept strictly confidential. Thank you for your assistance

Patient's Name	Date of Birth (required)	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Address / City / State / Zip		Home Phone (include area code) ( )
Social Security Number (required)	Driver's License Number	
Parent or Guardian's Name if Patient is a child	Email Address	
Name of Employer/Occupation		Business Phone (include area code) ( )
Person financially responsible for this account?	Address if different from above	
Will you be using medical insurance? ☐ YES ☐ NO	If no, how will you be paying? "Payment is required at time of service." ☐ CASH ☐ CHECK ☐ CREDIT CARD	
Whom may we thank for referring you to us?		

Primary Insurance Company Name	
Name of Insured Person/Relation to Client	Is the insurance through employer? ☐ YES ☐ NO
Date of Birth of Insured Person (required)	Social Security Number of Insured Person (required)
Subscriber Number	Group Number

Secondary Insurance Company Name	
Name of Insured Person/Relation to Client	Is the insurance through employer? ☐ YES ☐ NO
Date of Birth of Insured Person (required)	Social Security Number of Insured Person (required)
Subscriber Number	Group Number

I hereby authorize the above insurance company(s) to make payment directly to the provider for the benefits herein and otherwise payable to me. ***In addition, I understand that I am responsible for all charges, regardless of insurance coverage, and agree to pay for any services not covered by insurance.*** *I also authorize this office to release any information necessary to expedite processing of insurance claims.*

Client, Parent or Guardian
*Signature*____*Date*______________