Cheryl Lewis-Gilpatrick, MSW, ACSW, LICSW
Mill House Counseling Center
180 Locust Street
Dover, NH 03820
Phone: (603) 742-1373 ext. 102 **Fax:** (603) 742-1423

Client Intake Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Marital Status: _____

SSN: _____ Referred By: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Mailing Address (if different from above): _____

_____

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____

Parent/Guardian Information (If Applicable)

Name: _____

SSN:_____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Employer: _____ Work Phone: _____

Emergency Contacts Who May Be Contacted:

Name: _____ Relation: _____

Home Phone: _____ Mobile Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____ Relation: _____

Home Phone: _____ Mobile Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

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Billing Information

Will you be using insurance to pay for therapy? _____
Responsible Party: _____
Billing Address (if different from above): _____
City: _____ State: _____ Zip: _____
Insurance Name: _____
Insurance Company Address (usually located on the back of your card):_____
City: _____ State: _____ Zip: _____
Phone Number: _____
Policyholder: _____ SSN: _____
Certificate ID No.: _____ Group No.: _____

Secondary Insurance Name: _____
Insurance Company Address:_____
City: _____ State: _____ Zip: _____
Phone Number: _____
Policyholder: _____ SSN: _____
Certificate ID No.: _____ Group No.: _____

Please bring your insurance card with you to your appointment.

- **Do you need to get preauthorization from your insurance?** Yes No
- **If so, how many sessions did you receive? _____**
- **What is your authorization number? _____**
- **Do you have a deductible?** Yes No **What is it? _____**
- **What is the number of sessions per year allowed on your plan? _____**
- **Or your yearly amount in dollars that your plan will allow? _____**
- **Do you have a copayment?** Yes No **What is it? _____**

If I am a participating provider with your insurance company, I have an arrangement by which the insurance company will send me payments directly. You will be responsible for your copayment at the time of the session, unless we have a different agreement. If I am not a participating provider (and you should check on this before we meet) then please be prepared to pay for your session.

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Consent for the Release of Confidential Information

I, _____ authorize _____

to disclose to _____

the following information _____

_____

for the purpose of_____.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire 90 days from date of signature unless another date is specified.

Specification of the date, event or condition upon which consent expires: _____
_____.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

For Patient Records Applicable Under Federal Law 42 CFR Part 2.

Date: _____ _____
Signature of Client or Authorized Representative

_____
Witness Signature

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Family Information

Household Members:

Name: _____ Age: _____ Relation: _____

Name: _____ Age: _____ Relation: _____

Name: _____ Age: _____ Relation: _____

Name: _____ Age: _____ Relation: _____

Counseling History

Prior Treatment? Yes No

Location/Agency: _____

Dates: _____ Therapist: _____

Reasons for Treatment: _____

Hospitalizations: _____

Location: _____

Dates: _____ Physician: _____

Reasons: _____

Medical History

Personal Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Date of Last Physical Exam: _____

Current Medications: _____

_____

Hospitalizations [include: Location/Dates/Physicians]:_____

_____

Significant Medical Problems: _____

_____