[Logo]

Organization Name
Street Address city/state zip. Phone. Fax. Email. Website address

Clinical Intake Paperwork

SUPERVISING CLINICIAN name
Credentials

NPI:
personal E-mail

- Copy of insurance card is included front and back
- Copy of State ID/ Driver License is included
- Copy of CC is included front and back

Primary Insured Information:

Name: _____
Address: _____ City/State: _____ Zip: _____ DOB: _____ SS#: _____
E-mail: _____
Phone: _____
Insurance Co: _____
Employer: _____
Member ID: _____
Group ID: _____

Emergency Contact same as above:

Emergency Contact

Name: _____

Emergency Contact preferred method of communication: Text Phone Email

Phone: _____e-mail: _____

**Patient authorizes The Wellness Center and it's associates and affiliates to contact my emergency person including emergency services in cases of crises situations involving suicidal ideation, homicidal ideation and/or if I cannot be reached within 48 hours by other reasonable means.*

Patient Demographics:

☐ **Same as Above Patient is a minor**

Patient Name: _____

DOB: _____ SS# : _____

☐ Address same as Primary Insured

Address: _____ City/ State: _____ Zip: _____

Preferred means of contact:

Home Phone: _____

☐ Can leave a message on Voice Mail (VM) ☐ Cannot leave a message on VM

Cell Phone: _____

☐ Can leave a message on(VM) ☐ Cannot leave a message on VM

Email: _____

Text: _____

I understand that Text communication through cell service is not HIPAA compliant and agree that this is the most efficient method of communication. I agree to text with The Wellness Center, its associate and its affiliates. I have been given information about other protected means of communication and understand that texting does not protect my privacy rights. By my signature below I agree to text messages.

Signature: _____ *Date:* _____