INTAKE REQUEST FORM

Demographic Information

Name: _____ **Date of Birth**: _____

Address: _____ **Apt No.**: _____

City: _____ **State**: _____ **Zip**: _____

Phone: Home: _____ Cell: _____

Email: _____ **Sex**: _____

Insurance Information – (NOTE: COPY OF INSURANCE CARD – FRONT & BACK - MUST ACCOMPANY THIS FORM)

Primary Insurance Provider: _____

Policy Owner: _____ **Relationship to Patient**: _____

Date of Birth: _____ **Policy Number**: _____

Secondary Insurance Provider: _____ **Policy #**: _____

DESCRIBE WHAT YOU ARE SEEKING TREATMENT FOR:

PLEASE ANSWER THE FOLLOWING QUESTIONS

Referral Source: _____

Are you Interested in: ☐ Medication ☐ Therapy ☐ Both

I prefer sessions are: ☐ In-person ☐ Virtual

Are you currently receiving mental health treatment? ☐ Yes ☐ No

If yes, please describe which services:

_____

Signature: _____ **Date**: _____

Return the form to intakes@freedomfromfear.org