

Sue Moreland, MSW, LCSW
11415 NE 128th ST. Suite 100
Kirkland, WA 98034
425-820-7100

INTAKE FORM

Date: _____

Name _____ (please include middle initial)

Mailing Address _____ City _____ Zip _____

Residence address (if different) _____

Telephone: Home _____ Work _____

E-mail address _____ Use email for administrative matters? Yes / No

Birthdate _____ SS# (required to bill insurance) _____

INSURANCE INFORMATION (if applies to mental health services)

This information is necessary for services to be billed for you.

Insurance Co. _____

Billing Address _____ PH: _____

Subscribers Name _____ Birth date _____

Subscriber's SS# _____ Policy ID# _____

Group # _____ Subscriber's employer: _____

Co pay at time of visit _____ Percentage of coverage _____

Deductible _____ Month deductible is renewed _____ Currently met? - Yes / No

Number of sessions covered per year _____ Pre authorization required? Yes / No

Emergency contact _____ PH: _____

Physician _____ PH: _____

Current Medications and dosages _____

Prescribed by _____ PH: _____

Referred by _____

Why are you seeking therapy at this time? _____

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Insurance Billing Authorization

Client Name _____ SS# _____

If a minor parent or guardian's name _____

(Please initial each paragraph. If a minor parent or guardian must initial)

_____ I authorize Sue Moreland, MSW, CSW (or her assistant) to bill my insurance company for services rendered by her for me.

_____ I authorize Sue Moreland MSW, CSW to receive payment from my insurance company directly.

_____ I understand Sue Moreland will discuss with me the nature and content of information released to my insurance company beyond diagnosis and type of service and that this will happen during my sessions.

_____ I will hold Sue Moreland harmless for any loss of confidentiality related to the release of information necessary process claims to my insurance company.

_____ I understand if my insurance company does not pay for services I will be responsible for payment for services unless Sue Moreland's contract with my insurance company prohibits billing the patient directly for claims not authorized.

_____ I understand that I am responsible for the payment of the any deductibles, co pays or co insurance payments unless I am a minor. If I am a minor than my parent(s) or legal guardian(s) are responsible for these payments.

Signature _____ Date _____

Signature of parent or guardian _____ Date _____