



**Brighter Possibilities  
Child and Family Counseling**

**Intake Paperwork**

**PATIENT  
INFORMATION:**

Date \_\_\_\_\_ Client's Social Security # \_\_\_\_\_ Case# \_\_\_\_\_  
Client's First Name \_\_\_\_\_ LastName \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_F \_\_\_M Race \_\_\_\_\_  
Name of Spouse/Guardian \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person Responsible for Payment \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Signature of Person Responsible for Payment X \_\_\_\_\_ (Must be signed for services to begin)

**EMERGENCY INFORMATION**

**IN CASE OF EMERGENCY, CONTACT:**

Name (1) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Work \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name (2) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Work \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Psychiatrist \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Other Physicians \_\_\_\_\_ Phone \_\_\_\_\_  
Current Medications \_\_\_\_\_  
Allergies \_\_\_\_\_

**Employment Information** (If client is a child, use parent's employment)

Client/Guardian: Place \_\_\_\_\_ Phone \_\_\_\_\_ Hrs. \_\_\_\_\_  
Spouse: Place \_\_\_\_\_ Phone \_\_\_\_\_ Hrs. \_\_\_\_\_

**INSURANCE INFORMATION**

INSURANCE INFORMATION: (Present Insurance Card to Office Staff Please)

Primary Insurance Company: \_\_\_\_\_ Secondary Insurance Company: \_\_\_\_\_  
Card Holder \_\_\_\_\_ Card Holder \_\_\_\_\_

Birth Date \_\_\_\_\_ Birth Date \_\_\_\_\_  
SSN \_\_\_\_\_ SSN \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer \_\_\_\_\_ Employer \_\_\_\_\_  
Policy ID # \_\_\_\_\_ Policy ID# \_\_\_\_\_  
Group # \_\_\_\_\_ - \_\_\_\_\_ Group# \_\_\_\_\_ - \_\_\_\_\_

**REFERRAL SOURCE**

**HOW DID YOU HEAR OF OUR CLINIC (OR FROM WHOM)?**

Address \_\_\_\_\_ City \_\_\_\_\_ State\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship to referral source \_\_\_\_\_ Primary doctor \_\_\_\_\_

**RESTRAINING ORDER OR ORDER OF PROTECTION**

Is there currently a Restraining Order or Order of Protection on anyone? YES / NO

If so, what is the name of the individual(s)? \_\_\_\_\_

**BILLING INFORMATION – Read and sign:**

1. I authorize Brighter Possibilities to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, agency accountant(s), agency legal representatives, Brighter Possibilities Supervisor, and insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize Brighter Possibilities to release my medical records and billing information to my Primary Care and/or Referring Physician.
3. I authorize my insurance benefits to be paid to Brighter Possibilities
4. If a requested insurance claim is filed, I will receive a bill each month if my account has a balance due. I am responsible for any charges not paid by insurance.
5. I understand that if I do not provide the above insurance information, I will be responsible for my bill, regardless of whether or not I have insurance.
6. I understand that I am responsible for providing a referral to my insurance company if they require it.

Name of person completing this form (please print) \_\_\_\_\_

Signature of person completing this form \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_