

Suzanne V. Perry, LCSW, LLC

CLIENT INTAKE FORM

(Please print clearly)

Today's Date: _____

CLIENT(S) INFORMATION

Name(s): _____
Last First Name(s) Middle Initial

Address: _____
Street City State Zip Code

Birth Date: _____ Age: _____ Gender: Female Male

Marital Status:
 Never Married Partnered Married Separated Divorced Widowed

Number of Children _____ Number of Grandchildren _____

Home Phone: _____ May I leave a Msg? Yes No Best # _____

Cell/Other Phone: _____ May I leave a Msg? Yes No Best # _____

Employed Full-time Employed Part-time Part-time Student Full-time Student
Client's Condition Related to? Employment Auto Accident Other Accident

How did you hear about me/referred by? _____

Emergency Contact: _____ Relationship: _____

Phone Number Other Than Yours: _____

INSURANCE INFORMATION

Client Authorization Number/Code: _____

Name of Insurance Co: _____

Name of Policy Holder: _____
(If different from above) Last First Middle Initial

Insured's Address: _____
(If different from above) Street City State Zip Code

ID Number: _____ Social Security Number: _____

Group Number: _____ Date of Birth: _____ Gender: Female Male

Client's Relationship to the Insured: Self Spouse Child Other

Insured Person's Employer/School: _____
Authorization to Release this Information to Your Insurance Company is on the Second Page!

**AUTHORIZATION
RELEASE OF INFORMATION CONSENT FORM
HIPAA Compliant**

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

I authorize the release of any medical or other information necessary to process health insurance claims, to obtain authorizations, or for insurance-required reviews or audits on my behalf for the services rendered me by Suzanne V. Perry, L.C.S.W.

Signed: _____ **Date:** _____

PATIENT/INSURED OR AUTHORIZED PERSON'S SIGNATURE:

I authorize payments of medical benefits to SUZANNE V. PERRY, L.C.S.W., for services as described on Health Insurance Claim Form 1500 and submitted to my health insurance company on my behalf.

Signed: _____ **Date:** _____

Note: Insurance claims may be filed on paper or on secured insurance company websites as required by your health insurance company.

Service Facility Location Information/Billing Provider Information for Form 1500

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