

ADMINISTRATIVE INTAKE

Last Name	First Name	M.I.	Age	DOB	Social Security #
Street Address _____				Phone # Home	_____
				Cell	_____
				Work	_____
City	State	Zip Code			

Spouse/Significant Other: _____

In case of emergency contact: Name: _____

Primary Insurance: _____ Effective Date: _____
 (If the policyholder is different than client information above):

Last Name	First Name	M.I.	Social Security #
Address: _____		DOB: _____	
Relationship to Client: _____		Employer: _____	

Secondary Insurance: _____
 (If policy holder information is different from above): Name: _____

Address: _____ Relationship to Client _____
 Employer: _____

***It is your responsibility to inform Cook Counseling Services of changes in address, phone # and insurance coverage.**

Communications to you will be by phone, mail and possibly e-mail. Do you have objections to this: Y N
 (If yes, please complete a [Request for Confidential Handling of Health Information.](#))
(Our number will appear on the caller I.D. if we call you.)

In an effort to coordinate care, we would like to obtain/give information from previous providers and/or your referral source. With your written authorization, we will be informing your physician (by letter) of your diagnosis and care here, communicating, as necessary, with your referring agent and requesting past mental health records.

Do you wish to sign an authorization for the following? Please circle

Primary Care Physician/Psychiatrists/Clinic: (Sometimes it's desirable to confirm with a physician to consider potential medical conditions contributing to a psychological problem or to give information to your physician regarding psychological problems contributing to other conditions). _____ Yes No

Past Mental Health Providers _____ Yes No

Referral Source: _____ Yes No

I was informed of: Client Bill of Rights	Yes	No	I received: Notice of Privacy Practices	Yes	No
Grievance Procedures	Yes	No	Welcome to our clinic:	Yes	No

 Signature Date