Cathy T. Burns M.A. LPC-S
Licensed Professional Counselor
4211 I40 West, Suite 101
Amarillo, Texas 79106

Phone: (806) 350-5867 **Fax: (806) 358-4345**

CLIENT INTAKE FORM

(Please Print)

Today's Date _____/_____/_____

CLIENT INFORMATION

Client's Last Name First Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address City State ZIP Code	Social Security - -	Home Phone No. ( )
P.O. Box City State ZIP Code		Cell Phone No. ( )
Occupation / Employer		Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. _____ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Driver's License Info:	Annual Gross Family Income:

INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )
Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? _____

Please Select Your Primary Insurance Provider

❑ Amerigroup ❑ Beech Street ❑ Blue Cross/Blue Sheild ❑ ChoiceCare ❑ Cigna
❑ Definity Health ❑ First Health ❑ HealthSmart ❑ IPM ❑ Magellan/Aetna ❑ Menninger
❑ MHN/MHNet ❑ PHCS ❑ PMHS ❑ Texas One Choice ❑ TriCare ❑ United Healthcare
❑ Value Options ❑ Other _____

What is the authorization number? ❑ Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any) Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

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(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Cathy T. Burns LPC will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by Cathy T. Burns LPC. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to Cathy T. Burns M.A. LPC-S

X _____
CLIENT/GUARDIAN SIGNATURE DATE