

CLIENT INTAKE INFORMATION

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle Initial

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City, State Zip

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ok to leave message on home number: [ ] YES [ ] NO Ok to leave message on cell: [ ] YES [ ] NO

Please be advised that although JUEL’s Therapeutic Solutions use secure mobile phones, information stored on mobile phones is at risk of privacy breaches due to external circumstances (e.g., theft, data interception). By checking this box, you are aware and accept the risk of privacy breaches due to circumstances out of the control JUEL’s Therapeutic Solutions.

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note that although JUEL’s Therapeutic Solutions’ staff use secure e-mail, e-mail is at risk of privacy breaches due to external circumstances (e.g., identity theft, data interception). By entering your e-mail address, you accept the risk of privacy breaches due to circumstances out of the control of JUEL’s Therapeutic Solutions.

In case of Emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Cell Phone Home Phone

FINANCIAL RESPONSIBILITY

Self-Pay: [ ] YES [ ] NO Insurance: [ ] YES [ ] NO

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All self-pay fees, copayments and co-insurance are required at the time of service. In-network insurance claims will be submitted by the provider on your behalf. All out-of-network claims are the client’s responsibility and can be submitted to your insurance company for out-of-network reimbursement. JUEL’s Therapeutic Solutions, LLC does not resume the responsibility for any out-of-network claims that are not reimbursed by your insurance carrier.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that the above information is true and accurate. It is my responsibility to notify and communicate, in writing, any changes to JUEL’s Therapeutic Solutions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name Client/Guardian’s Signature Date

REFERRAL SOURCE: How did you hear about JUEL’s Therapeutic Solutions?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Website [ ]  Brochure [ ]  Internet Search [ ]