Cleckler Psychological Services, LLC

New Patient Intake Form

Provider: _____ **Date of First Appointment:** _____

Patient: _____ **Patient Date of Birth:** _____

Phone #: _____ **Email:** _____

May we send patient statements to this email address? **Yes:** _____ **No:** _____

Address **Street:** _____

City: _____ **State:** _____ **ZIP:** _____

Primary Insurance Information (Collect copy of insurance card (front and back))

Insurance Carrier: _____ **Member ID:** _____

Policy Holder Name: _____ **Date of Birth:** _____

Mental Health Benefits Ph#: _____

Secondary Insurance Information (Collect copy of insurance card (front and back))

Insurance Carrier: _____ **Member ID:** _____

Policy Holder Name: _____ **Date of Birth:** _____

EAP Benefits Information

Insurance Carrier: _____ **Employer:** _____

EAP Phone #: _____ **Authorization #:** _____

# of Visits Authorized: _____

Notes / Additional Information

Prepared By

Signature _____ *Date* _____