FAMILY THERAPY OF ALBUQUERQUE, INC.

A Ministry of Heights Cumberland Presbyterian Church

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

LIST PHONE NUMBERS AND INDICATE IF IT IS OKAY TO LEAVE A MESSAGE BY CHECKING YES OR NO FOLLOWING THE NUMBER.

PLEASE NOTE: IF WE LEAVE A MESSAGE AT ANY OF THESE NUMBERS WE WILL PROTECT YOUR CONFIDENTIALITY AND ONLY IDENTIFY OURSELVES AS FROM HEIGHTS CUMBERLAND PRESBYTERIAN CHURCH

Home Phone _____ Yes☐ No☐ Mobile Phone _____ Yes☐ No☐

Work Phone _____ Yes☐ No☐ Pager Number _____ Yes☐ No☐

Age____ Date of birth _____ Sex M☐ F☐ Social security number _____

Marital status: ☐Single ☐Married ☐ Divorced ☐Widowed ☐Separated☐

Occupation _____ Employer _____

Who referred you to Family Therapy? _____

Please list allergies or adverse reactions to food/medications _____

Medical conditions and list of current medications: _____

Name of your physician _____ Phone Number _____

Are you a member of a church? _____ Name of church _____

Have you had previous counseling? Yes☐ No☐ Where _____

Name Of Spouse _____ Social Security Number _____

Age_____ Date Of Birth _____ Sex M☐ F☐

Address _____

City _____ State _____ Zip _____

Occupation _____ Employer _____

Home Phone _____ Yes☐ No☐ Mobile Phone _____ Yes☐ No☐

Work Phone _____ Yes☐ No☐ Pager Number _____ Yes☐ No☐

Please list allergies or adverse reactions to food/medications _____

Medical conditions and list of current medications: _____

Emergency contact: Name, Phone # and relationship to client _____

Names of other persons living in your home	Relationship	Date Of Birth	Occupation/Employer

Over Please

Do you have insurance? Yes☐ No☐

Do you want to use your insurance? Yes☐ No☐ If yes, please fill in box below.

INSURANCE INFORMATION

Primary Insurance Co. _____ Phone _____

Name Of Insured _____ Birthday _____

ID # _____ Group # _____

Social Security #. _____

PARENT PLEASE COMPLETE THE FOLLOWING INFORMATION

This information will be used to help us determine your portion of the payment for services based on our Schedule of Maximum Personal Expense.

Please state the total annual or monthly gross income earned by persons living in your home who are combining finances.

Per Month $ _____ Per Year $ _____

Please state the number of persons living in your home who are combining finances and are dependent on this income._____

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE.

SIGNED _____ DATE _____

I authorize the release of any medical or other information necessary to process claims. I also authorize payment of medical benefits to the physician or supplier for services rendered.

SIGNED _____ DATE _____

FOR OFFICE USE ONLY

Referral Type _____

Referred To _____ Date _____

Date of Information Session _____

Date Client First Contacted _____

Number Of Work Days To Process Intake _____

Chief Complaint _____

Comments:

Portion Of Standard Fee Based On Schedule Of Maximum Personal Expense _____