Alder Psychological Services, LLC

INTAKE INFORMATION

(To be completed by client)

IDENTIFYING INFORMATION Today's Date________________________

Legal Name: ________________________ Preferred Name: ________________________

Date of Birth: ________________________ Age: ________________________

Address: ________________________ **City, State, Zip:** ________________________

Home phone: ________________________ **Cell phone:**________________________

Social Security (ID) Number: Self: ________________________ **Gender as Specified on Insurance:** ☐ Male ☐ Female

INSURANCE INFORMATION

Insurance Company:________________________Phone: ________________________

Insurance Company Address: ________________________City, State, Zip:________________________

Insurance Identification Number: ________________________**Group Number:** ________________________

Secondary insurance: ________________________Phone: ________________________

Secondary Company Address: ________________________City, State, Zip:________________________

Secondary Identification Number: ________________________**Group Number:** ________________________

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process an insurance claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

____ ________________________

Signature Date

FOR PROVIDER USE ONLY

DSM-5: DIAGNOSIS: ICD-10 DIAGNOSIS: