INTAKE FORM

DATE: _____ **REFERRED BY:** _____

PATIENT INFORMATION

NAME: _____ **DOB:** _____ **AGE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE 9-digit** _____

TELEPHONE (HOME): _____ **(CELL):** _____ **(WORK):** _____

PREFERRED PHONE ☐ **HOME** ☐ **CELL** ☐ **WORK** **E-MAIL*** _____
*for appointments and notifications only

GENDER: ☐ **Male** ☐ **Female** **Ethnicity:** _____

GENDER IDENTITY ☐ **Female to male (FTM)/transgeder male/trans male** ☐ **Male to female (MTF)/transgender female/trans female** ☐ **Queer** ☐ **CHOOSE NOT TO DISCLOSE**

SEXUAL ORIENTATION: ☐ **Lesbian/gay/homosexual** ☐ **Straight/heterosexual** ☐ **Bisexual** ☐ **CHOOSE NOT TO DISCLOSE**

MARITAL: ☐**Single** ☐**Significant other/partner** ☐ **Married** ☐**Separated** ☐ **Divorced** ☐ **Widowed**

SOCIAL SECURITY #: _____ **DRIVER'S LICENSE #:** _____

EMPLOYER: _____ **OCCUPATION:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

TELEPHONE (HOME): _____ **(CELL):** _____ **(WORK):** _____

NEXT OF KIN: _____ **RELATIONSHIP:** _____

TELEPHONE (HOME): _____ **(CELL):** _____ **(WORK):** _____

MOTHER'S MAIDEN NAME _____ **FIRST NAME** _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____ **PHONE:** _____

POLICY NUMBER: _____ **HOLDER'S DOB:** _____

EMPLOYER: _____ **GROUP NUMBER:** _____

GUARANTOR (POLICY HOLDER) INFORMATION

GUARANTOR NAME: _____ **DOB:** _____ **AGE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

TELEPHONE (HOME): _____ **(CELL):** _____ **(WORK):** _____

SOCIAL SECURITY #: _____ **RELATIONSHIP TO PATIENT:** _____

EMPLOYER: _____ **GROUP NUMBER:** _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: _____ **PHONE:** _____

POLICY HOLDER: _____ **RELATIONSHIP:** _____

POLICY NUMBER: _____ **HOLDER'S DOB:** _____

EMPLOYER: _____ **GROUP NUMBER:** _____

RESPONSIBLE BILLING PARTY (ONLY IF DIFFERENT FROM ABOVE)

NAME: _____ **DOB:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

TELEPHONE (HOME): _____ **(CELL):** _____ **(WORK):** _____

SOCIAL SECURITY #: _____ **RELATIONSHIP TO PATIENT:** _____

EMPLOYER: _____ **OCCUPATION:** _____

PRIMARY CARE PHYSICIAN (PCP) INFORMATION AND RELEASE

PROVIDER NAME: _____ **PHONE:** _____ **FAX:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

I GIVE MY CONSENT FOR DR. MOTOIKE TO COMMUNICATE WITH MY PCP. _____
[Includes, but is not limited to, outpatient notification letter and contact for coordination of care] **(Signature)**

I DO NOT GIVE CONSENT FOR DR. MOTOIKE TO COMMUNICATE WITH MY PCP. _____
(Signature)

OTHER PRESCRIBING PROVIDER INFORMATION AND RELEASE (e.g. psychiatrist, endocrinologist, pain specialist):

PROVIDERNAME: _____ **PHONE:** _____ **FAX:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

I GIVE MY CONSENT FOR DR. MOTOIKE TO COMMUNICATE WITH MY PROVIDER. _____
[Includes, but is not limited to, outpatient notification letter and contact for coordination of care] **(Signature)**

I DO NOT GIVE CONSENT FOR DR. MOTOIKE TO COMMUNICATE WITH MY PROVIDER _____
(Signature)

If you have other prescribing providers or former behavioral health providers (e.g. former therapists or psychiatrists), please complete an Authorization Form

ALL 3 SIGNATURES BELOW ARE REQUIRED:

RELEASE OF MEDICAL INFORMATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM TO MY INSURANCE COMPANY. I UNDERSTAND THAT THIS RELEASE IS FOR THE PURPOSE OF BILLING AND REIMBURSEMENT.

X _____ _____
SIGNATURE OF PATIENT OR PRIMARY GUARANTOR **DATE**

ASSIGNMENT OF INSURANCE BENEFITS

I AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO JANICE MOTOIKE, Ph.D. FOR SERVICES PROVIDED I ALSO ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

X _____ _____
SIGNATURE OF PATIENT OR PRIMARY GUARANTOR **DATE**

CONSENT FOR TREATMENT

I HEREBY REQUEST AND CONSENT TO TREATMENT RENDERED BY JANICE MOTOIKE, Ph.D. THIS CONSENT IS FOR VOLUNTARY TREATMENT ON AN OUTPATIENT BASIS.

X _____ _____
SIGNATURE OF PATIENT OR GUARDIAN **DATE**