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Confidential Client Intake Information

*IF I AM ON YOUR INSURANCE PLAN, BRING YOUR CARD TO THE FIRST SESSION. (otherwise you will need to pay for the session.)
* HAVE YOUR CHECK OR CREDIT CARD READY TO PAY AT THE BEGINNING OF EACH SESSION.
* SESSIONS LAST ABOUT 45 MINUTES; BE ON TIME SO THAT YOU DO NOT SHORTEN YOUR TIME.

Date- Session 1 _____ Your Email (**Please print clearly**) _____
Confirm Email: _____

CLIENT INFORMATION

Name of Client _____ SS# _____ DOB _____
Address _____ Best Phone Number _____
Medical Doctor (PCP) _____ Telephone _____
Medications and dosage per day _____
Emergency Contact Name _____ Telephone: _____
If Client is a minor, who has custody? _____

Who referred you?

____ Pastor (Please give name) _____ Phone _____
____ Family/Friend (Please give name) _____
____ Physician (Please give name) _____ Phone _____
____ Insurance _____
____ Shepherd's Guide _____
____ Web site _____
____ Other (Please give name) _____

IF YOU PLAN TO USE INSURANCE

Name of the Insured Person _____ DOB _____
Best Phone number _____ Place of Employment _____

Name of Insurance for Mental Health _____ (on back of card)
Address _____ Phone Number _____

THE FIRST SESSION

- **I understand that if I do not have authorization or if I have not called my insurance to verify coverage that I will have to pay for the first session. _____ (initial)**
- **I also understand that if I am unable to come to a session, I must call and give 24 hours notice or I will be charged for the session. _____ (initial)**

I have read the office policies and by signing I agree to comply with all of them.

Signature _____ Date _____ Witness _____ Date _____

Relationship to Client (if not self): _____