

Keystone Counseling * 104 W. Main St. Ste# 206 * Puyallup, WA 98371 *
Phone: 253.651.3377 Fax: 877-343-6668

Intake & Insurance Form – Complete form and FAX it 24 hrs prior to 1st Session
This information is needed for submitting claims and/or auditing purposes. Please fill in all areas.

Client Name: _____ **DoB:** _____ **Age:** _____

Home Address: _____
Address City Zip

Phone #'s: Home: _____ **Cell:** _____

Is it ok to leave a message at these numbers? Yes No

Employer: _____

Work Address: _____

Work Phone: _____ **Current Position:** _____

Is it ok to leave a message at work? Yes No **Current Salary:** _____

In case of an emergency, whom should we contact?

Name: _____ **Phone:** _____

Relationship: _____

INSURANCE REQUIRED INFORMATION:

Insurance Co.: _____ **Subscriber ID#:** _____ **SSN:** _____

Customer Service phone number(usually on back of card): _____

Main Subscribers Name : _____ **Plan / Group #:** _____

Employer who Insurance is through: _____

Authorization # (if required): _____ **# of visits allowed (12 or 24 months)** _____

Start date _____ **Renewal date** _____

Co Pay : _____ **Deductible/ Co-Insurance% :** _____

Eff.date of Insurance: _____

Do you have out of network benefits if Counselor is not a preferred provider? _____

(This information is not a guarantee of coverage , we will not know your exact benefits & coverage until we receive a explanation of benefits from your insurance company.)

How did you learn about Keystone Counseling?

Internet (Please circle one: Google, Bing, Yahoo, Counsel Search.com, Psychology Today, Other _____)

Phone Book (Dex, YellowBook, other _____)

Other provider/clinic: _____

Friend/Referred by someone else: _____

Other (Flyer, Publication, _____)

Please note: This information helps me track how clients learn about my services. Confidentiality will not be violated.

I understand that I am financially responsible for services in the event my insurance does not cover services. I authorize my therapist to contact the insurance company for pre-authorization, if required by the insurance company.

Client Signature: _____ **Date:** _____

For Office Use Only: Insurance Authorization: _____

Client Name: _____ Client# _____

Therapist Name: AnnaMarie Pedersen, MA LMFT Signature: _____