HAVEN PSYCHOLOGICAL ASSOCIATES
8253 White Oak Avenue
Rancho Cucamonga, CA 91730
Phone: (909) 987-1997 **www.havenpsych.com** **Fax: (909) 987-0993**

CLIENT INTAKE FORM

(Please Print)

Today's Date: _____/_____/_____ **Therapist: _____**

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. _____ ❑ Insurance Plan ❑ Website

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

INSURANCE INFORMATION (PLEASE GIVE YOUR ID AND NSURANCE CARD TO THE CLINICIAN)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Occupation			Cell Phone No. ( )
Employer	Employer Address		Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an Employee Assistance Program visit? ❑ Yes ❑ No	Name of EAP: _____
Insurance Company Phone Number: ( )	Phone No. of EAP: ( )	Total Annual EAPs allowed? _____

Please Select Your Primary Insurance Company

❑ Aetna ❑ Anthem ❑ Blue Shield CA ❑ Blue Cross/Blue Shield National
❑ Beacon Health ❑ CIGNA ❑ Holman ❑ Magellan ❑ Medicare
❑ Managed Health Network/HealthNet ❑ Tricare ❑ Optum/United Behavioral Health
❑ Value (Beacon) Options ❑ Other _____

What is the authorization number? ❑ Self Pay

Primary Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

(Please complete the other side of this page.)

HAVEN PSYCHOLOGICAL ASSOCIATES

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

- I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

- I understand that I am responsible for my fee payment at the beginning of each appointment.

- I understand that all appointments not cancelled 24 hours prior to the session will be billed to the client.

- I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be obtained. Your therapist will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

- I understand that Haven Psychological Associates (HPA) is an association of independently licensed and practicing professionals who share certain expenses and administrative functions. While members of this association share a name and office space, each therapist is completely independent in providing clinical services and each therapist is fully responsible for those services. Professional and clinical records are maintained separately and may not be accessed by any other member of this association without your written permission.

- I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

- I authorize the payment of medical benefits to the provider of services.

X _____

CLIENT/GUARDIAN SIGNATURE DATE