Wayne Townsend, LCSW
3729 Benson Dr. Raleigh, NC 27609

Initial Intake

Name _____ Date _____ DOB _____

Address _____ City _____ Zip _____

Phone (home) _____ (work) _____ (cell) _____

Source of referral _____

The problem (s) for which I am seeking consultation _____

_____

Prior psychotherapy / psychiatric experience ___Yes ___ No When _____

Medical conditions _____

Current medications _____

Occupation _____ How long? _____

Employer _____

List name, age, and relationship of those living with you _____

_____

Alcohol use (what, how much, how often) _____

Usual social activities or hobbies _____

Attend church / synagogue? ___Yes ___ No Denomination _____

Emergency contact _____ Relation to you _____

Phone _____

Additional concerns, comments, or questions

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Payment Options and Insurance Information

Option 1

Do not file insurance for me. I will pay for each session p

Signature _____ Date _____

Option 2

Please file my insurance

Policy holder's name _____ Date of Birth _____

Insurance Co. _____ Is Pre-Authorization required? _____

Insurance ID _____ Employer _____

Claims Address (usually on back of card _____

A. I would like for you to file my insurance. My copay is _____ and I agree to pay this at each session. Initial ____
B. I accept that I am responsible for knowing the terms of my health insurance coverage including policies for mental health coverage (often different from regular medical visits), copay, deductible, and that I will be responsible for allowed balance not paid by insurance. Initial ____
C. I also understand that insurance does not cover missed appointments and I agree to pay for sessions that I miss without a prior call to cancel (24 hour notice). Initial ____
D. I understand that psychotherapy is protected by confidentiality and that no one can be contacted without my written permission. Some emergencies / safety issues are exceptions. Initial _____

Name (print) _____ Signature _____