Lowry Hill Psychotherapy & Assessment Center

1910 Hennepin Avenue South | Minneapolis | MN | 55403
Phone (612) 871-2544 | Fax (612) 814-0668 | psychotherapy@lowryhillpac.com

INTAKE PAPERWORK

Name: _____ Date: _____

Address: _____

City & State: _____ Zip: _____

Gender: _____ Date of Birth: _____

Is it ok to leave a message at this number?

Phone #: _____ Yes _____ No_____

Email: _____

INSURANCE CARRIER(S)

Primary Insurer: _____

ID#: _____ Group#: _____

Secondary Insurer: _____

ID#: _____ Group#: _____

PLEASE INCLUDE A COPY OF CLIENT'S INSURANCE CARD (FRONT & BACK)

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Phone #: _____

WHAT BRINGS YOU IN AT THIS TIME?

_____

_____

List current partner, children, and/or others in your household:

NAME	GENDER	AGE	RELATIONSHIP TO YOU

Do you ever feel unsafe in your current living situation? If so, please explain:_____

_____

_____

Describe your current health concerns (e.g., diet, exercise, sleep, chronic health problems, etc.):_____

_____

_____

Current medications: _____

Date of last physical exam: _____

AUTHORIZATION OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I authorize payment of my benefits to Lowry Hill Psychotherapy and Assessment Center for mental health and/or assessment services rendered. I understand that I will be responsible for any cost accrued which are not covered by my insurance company.

I also authorize the release of pertinent information (e.g. diagnosis) regarding these claims to my insurance company, as requested by the company. Payments should be mailed to:

Lowry Hill Psychotherapy & Assessment Center
1910 Hennepin Avenue South
Minneapolis, MN 55403

A photocopy or electronic version of this authorization shall be as valid as the original.

Client's Signature _____ Date _____

Print Client Name _____

Parent or Guardian's Signature (if applicable) _____ Date _____

Therapist's Signature _____ Date _____

SIGNATURES PAGE

Client's Printed Name

In the event of Emergency, I authorize an individual at Lowry Hill Psychotherapy & Assessment Center to call my emergency contact.

Client's Signature | Date

Parent or Guardian's Signature (if applicable) | Date

My signature below indicates that I have read and understand the information in the policies and procedures document. I agree to abide by its terms while receiving services. I was given a copy of this document.

Client's Signature | Date

Parent or Guardian's Signature (if applicable) | Date

My signature indicates that I understand my rights as a client and have been offered a copy of HIPAA regulations, the MN Psychologists Policies and Practices to protect the privacy of patient health information and the Client Bill of Rights.

Client's Signature | Date

Parent or Guardian Signature (if applicable) | Date

Therapist's Signature | Date