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Intake for Child (under 18)

If two separate households, please duplicate this form and fill out separate form for each, thank you. Note that for separated/divorced parents, I will need BOTH signatures.

Child's Name _____ Date _____

Birthdate _____ Social Security # _____

Name(s) of Parent(s) _____

Mailing Address _____

City & Zip Code _____ Okay to leave phone message? _____

Home Phone _____ Work Phone _____ Cell Phone _____

Parents' Occupations _____

Parents' Employers _____

Child's School _____ Grade level _____

Teacher _____ School Psychologist _____

Name of person or organization responsible for fees if different from above

Persons Living in Household (also use other side if you need more room)

Name	birthdate/age	M/F	Occupation	Relationship
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Presenting Problem (what he/she need counseling for) _____

Has your child previously seen a therapist? _____ Whom _____

When _____ Why did your child stop therapy with this
clinician? _____

Is your child currently taking medication? _____ Please list name of medicine,
strength, number of pills, and how often taken

Child's Primary Care Physician _____

Referral Source (how did you hear about me?) _____

Insurance Information for billing:

Do you have medical insurance that covers psychological services? Yes ___ No ___

Name of insurance company _____

Address _____

Subscriber's Name _____

Subscriber Insurance Number _____

Subscriber Social Security Number _____

Subscriber Date of Birth _____

I will also need a copy, front and back, of your insurance card.

Please read and sign the attached consent for treatment. Thank you.

Note that by signing the attached "Consent to Treatment" contract you are agreeing to pay for sessions if your insurance company refuses payment, and you are agreeing to pay for sessions after your insurance authorized sessions have reached your policy limits.