THE HEALTH AND WELLNESS SOURCE, LLC*4230 Forbes Blvd. Suite A, Lanham, MD 20706
NEW CLIENT INTAKE/Group Therapy Registration FORM

Client FULL Name: _____ DOB: _____ Age/Grade: _____
(person being seen today)
Gender: ___M ___ F Marital Status: ___Single ___ Married ___ Separated ____Divorced **SSN:_____**
Address:_____City:_____State:_____ Zip:_____
Home Ph:_____ Cell Ph:_____ Work ph:_____

Email: _____ Occupation ***or SCHOOL***: _____
Parent/Guardian *(if a minor)*:_____ Ph:_____
Relationship to Client_____ Languages Spoken:_____
Emergency Contact Name:_____ Phone_____

Services Requested *(please check all that apply):*

_____Individual Therapy ____ Family Therapy ____ Marital/Couples Therapy _____ **Group Therapy** _____ Sports/Athletic Conditioning ___ **PRP**

Reason(s) for Referral:

_____

HOW DID YOU HEAR ABOUT US? _____ Referred By: _____

FEES: GROUP=$25 per session *(payment may be made prior to each group session or entire group series may be paid in advance)*
Billing Information- I will be using: ____ Insurance *or* ____ Self-Pay: *(___ Cash ___ Check or ___ Debit/Credit-see below)*

Name/Type of Insurance: _____ Health Plan/Type: _____

ID # _____ Group # _____ Co-pay amount: $_____
Name of Sponsor/Subscriber: _____ Effective Date: _____

Medical Claims Mailing Address *(on back of insurance card)*:_____
Claims Telephone Number: _____ City/STATE/ZIP:_____

CREDIT/DEBIT CARD INFO. for Co-Pays/Self-Payments *(5% debit authorization fee)*

Name on Card: _____

Billing Zip CODE: _____ Debit Card Type: _____ Visa _____ Master Card

Debit Card Number: _____-_____- _____-_____

Expiration Date: _____/_____ 3-digit code (on back of card): _____

Consent to Treatment *(to be completed by CLIENT or PARENT/GUARDIAN, if client is under 18):*

I, _____,voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize **THWS/Sharon Richardson, LCSW-C,** to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the treating therapist at any time. By signing this consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. I authorize **THWS/Sharon G. Richardson, LCSW-C** and employees and agents to release information pertinent to billing and collecting any outstanding balances on my account. I authorize payment of medical insurance benefits to be made directly to **Sharon G. Richardson, LCSW-C.**

By my signature I acknowledge that the information above is true and correct.

_____ _____

Client Signature (*or Parent/Guardian, if under 18)* **Date**

www.thehealthandwellnesssource.com