REDMOND REAMS, Ph.D.

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CHILD CLIENT INTAKE FORM

Child's Name:_____ Date of Birth:_____

Address:_____City&State:_____Zip:_____

Home Phone:_____ Home e-mail:_____

Mother's Name: _____

Address (if different):_____

Phone (if different):_____ E-mail (if different):_____

Work Phone:_____ Cell phone:_____

Father's Name:_____

Address (if different):_____

Phone (if different):_____ E-mail (if different):_____

Work Phone:_____ Cell Phone:_____

Other members of the household and their ages: _____

If using insurance, please consult your benefit booklet and/or call the 800 phone number on the back of the insurance card in order to complete the following questions:

Insurance company's name: _____ Group #:_____

Claims address (from back of insurance card):_____

Name of insured:_____ Insured's date of birth: _____

Insured's ID number:_____ Insured's employer:_____

Do you need a preauthorization for outpatient mental health services? **Yes**☐ **No**☐

If yes, do you have one? **Yes**☐ **No**☐

If yes, what is the authorization number: _____

If yes, how many therapy sessions have been authorized? _____

What is the maximum number of therapy sessions in a certain time period?_____

What is that time period (e.g. calendar year, 24 months starting from date of 1 session)?

What is your co-pay? _____ What is your relevant deductible amount? _____

When does the deductible renew?_____