

Awakenings Family Therapy, PLLC  
Laurie Snyman, MSW, CSW, ACSW

INTAKE DATE: \_\_\_\_\_ COMPLETED BY: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

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**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY/STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **WORK PHONE:** \_\_\_\_\_

**SEX:** Male      Female      **MARITAL STATUS:** Single      Married      Divorced

**DX:** \_\_\_\_\_ **YOUR EMAIL:** \_\_\_\_\_

**RESPONSIBLE PARTY:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY/STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **WORK PHONE:** \_\_\_\_\_

**INSURANCE #1:** \_\_\_\_\_

**POLICY #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**POLICY HOLDER:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**INSURED DOB:** \_\_\_\_\_ **EMPLOYER:** \_\_\_\_\_

**INSURANCE #2:** \_\_\_\_\_

**POLICY #:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**INSURED DOB:** \_\_\_\_\_ **EMPLOYER:** \_\_\_\_\_

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**EMERGENCY CONTACT (OTHER THAN SPOUSE)**

**NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **WORK PHONE:** \_\_\_\_\_

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**INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY)**

In order to submit a claim for payment to us for services covered under your policy, we must have authorization to release medical information to our billing company for paper and electronic billing and your insurance company.

I authorize release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Laurie Snyman, MSW, CSW, ACSW's billing company to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to Laurie Snyman. If I have Medicare insurance, I authorize Laurie Snyman to release to Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by Laurie Snyman by written request.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_ **DATE:** \_\_\_\_\_