

Karen Hansen, Ph.D., LMHC, MBA
Licensed Mental Health Counselor since 1999
(425) 361-3908

INITIAL INTERVIEW FORM

Date: _____

CLIENT INFORMATION:

Name: _____

Phone: (Wk) _____ (Hm) _____

Address: _____ City: _____

State: _____ Zip: _____

Sex: Male _____ Female _____ Date of Birth: _____

Others living at home: _____

Employer: _____ Occupation: _____

How long have you worked there? _____ How long in this occupation? _____

Education: (List highest level of education attained) _____

Primary Physician: _____ Phone: _____

List any significant health problems: _____

List any medications you are taking and the dosage: _____

Have you seen this type of therapist before? YES __ NO _____

If yes, when and with whom? _____

Give a brief description of treatment: _____

How were you referred to our office? _____

Who may we thank for referring you? _____

Nearest relative other than spouse: _____

Insurance Verification for Outpatient Mental Health with Licensed Mental Health Counselor

Client Member ID: _____

Insurance Name: _____ Insurance Phone #: _____

Group #: _____ Employer: _____

Is there any other insurance plan? Yes No If so, what company? _____

Date Verified: _____ Verified with whom: _____

Insurance Benefits Effective Date: _____

Insurance Verification continued:

Am I (Karen Hansen) In-Network for this client? Yes No

Deductible: _____ Deductible met already: _____

Date deductible begins: _____

Co-Pay Amount: _____ Percentage Insurance pays: _____

Number of annual visits: _____ Number used so far: _____

Mail claims to: _____

Patient Confirmation of Insurance provisions: Please call your insurance company at the number above and verify the information I was told. If there are any differences, please note below and let me know. Also, write down the name of the person with whom you spoke and the date.

Differences: _____

Person you spoke to: _____ Date: _____

Patient agreement to cover any costs not covered by insurance: I do my best to obtain reliable information regarding your insurance coverage, but there is no guarantee of payment until the company has actually paid out. With this in mind, please review this information, initial, and sign below.

_____ *I agree to reimburse Karen Hansen, LMHC, for any services not covered by my insurance, knowing that insurance companies issue a disclaimer that benefits quoted do not guarantee payment.*

_____ *I also realize that any deductible I have will need to be paid at the beginning of my calendar year.*

_____ *For insurance companies where Karen is out of network (e.g., Blue Cross), I agree to write a check to her for reimbursement after the check comes to me (unless, of course, I am paying her up front for her full fee.)*

Client: _____ Date: _____