Amy Buckman, LCPC, LPC

7381 W 133rd St, Overland Park, KS 66209
Phone: (913) 484-8294 | Fax: (913) 270-0064

CLIENT INTAKE FORM

Date: _____

Name: _____ (Last First M.I.)

Employer: _____

Address: _____

Work Phone: _____

_____

School/Grade: _____

Home Phone: _____

Occupation: _____

Date of Birth: _____

Relationship to Insured: _____

Soc. Sec. #: _____

Marital Status: Married ☐ Sep ☐ Div ☐ Widow ☐ Single ☐ Co-Habit ☐

Emergency Contact: _____
Phone #: _____

PRIMARY INSURANCE INFORMATION

self ☐ parent ☐ spouse ☐ guardian ☐

Name _____ (First M.I.)

Insured's Employer _____

Address _____ (if different)

Work Phone (_____)_____

_____

Insurance Co _____

Home/Cell Phone _____ (if different)

Plan Name _____

Birthdate _____

Insured's ID # _____

Soc. Sec. # _____

Policy Group # _____

RESPONSIBLE PARTY/SECONDARY INSURANCE

self ☐ parent ☐ spouse ☐ guardian ☐

Insured's Name _____ (Last First M.I.) Insured's Employer _____

Address: _____ (if different)

Work Phone (_____)_____

_____

Insurance Co. _____

Home/Cell Phone: _____ (if different)

Plan Name _____

Birthdate: _____

Insured's ID # _____

Soc. Sec. #: _____

Policy Group # _____

Authorization to Pay Benefits to Provider: I authorize payment of insurance benefits to Amy Buckman, LCPC, for services rendered. I further authorize the release to my insurance company of any medical or other information necessary to process my insurance claims. I understand that I am responsible for all balances unpaid by my insurance company, including but not limited to, deductibles and co-pays.

_____
Signature of Responsible Party

PERSONAL INFORMATION

Name:_____

Referred by: _____

Previous Counseling/Treatment:

(Who) _____ (Where) _____ (When) _____

(Results)_____

(Who) _____ (Where) _____ (When)_____

(Results)_____

Nature of Current Problems: _____

_____

_____

_____

Others Living in the Home:

Name _____ DOB ___/___/___ School/Employer: _____

Name _____ DOB ___/___/___ School/Employer: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Date of Last Visit: _____

Address: _____ Medical Issues: _____

Physician's Phone: _____ _____

Allergies: _____ Current Medications: (Include dosage and length

of usage)_____

Adverse Reaction to Medications _____

Substance Use:

Type	Frequency	Amount	Past Use/Problems
Tobacco			
Caffeine			
Alcohol			
Illegal Drugs			

Personal Concerns:

_____ anger
_____ anxiety
_____ guilt
_____nightmares
_____ difficulty concentrating
_____ overwhelmed by feelings
_____ relationship problems
_____ loneliness
_____ excessive fears
_____ feeling numb
_____ unhappiness/depression
_____ sensitivity (feelings hurt easily
_____ job dissatisfaction
_____ sexual concerns
_____substance abuse
_____ substance abuse (other)
_____ learning problems
_____ medical concerns
_____ other(s), please specify _____

_____ thoughts of hurting others
_____ physical abuse by another
_____ physical violence towards another
_____sexual abuse
_____ stalking
_____ legal problems
_____ racing thoughts
_____paranoia
_____blackouts (periods of time you don't recall)
_____ sense of unreality/hallucinations/delusions
_____ sleep problems
_____ appetite changes
_____ body dissatisfaction
_____ problems with children
_____ therapy required/urged by another party
_____ caregiver issues
_____ memory problems
_____ thoughts of hurting yourself

_____

Financial Policy

Co-pays for clients covered by insurance are due at the time services are rendered. For clients who are not using an insurance plan with which this therapist has contracted or are not using insurance, payment is due at the time of service. If you are unable to pay the entire amount, a payment of at least fifty percent (50%) of fees is required. An insurance form will be provided that can be filed with your insurance company for reimbursement.

If your insurance company requires you to obtain prior authorization and you do not, the cost of that visit will be your responsibility. IF YOU FAIL TO NOTIFY AMY BUCKMAN'S OFFICE OF CANCELLATION TWENTY-FOUR (24) HOURS PRIOR TO YOUR SCHEDULED SESSION (ALSO REFERRED TO AS A "NO-SHOW"), YOU WILL BE CHARGED FOR THE FULL COST OF THAT SESSION. Insurance companies ordinarily will not pay for missed/no show sessions.

It is not unusual for many children to live in more than one household. While you and your child's other parent may have an agreement about paying for health-related costs, Amy Buckman is not in a position to act as intermediary in that process. The parent who brings a child to the initial visit and signs as the Responsible Party (above) will be considered ultimately responsible for all patient balances.

I have read, understand and agree to the above-stated policies.

_____ _____

(Signature of Responsible Party) Date