# LYSA WEBB, MA LPC

5319 SW Westgate Drive Suite #211-A Portland Oregon 97221
503-515-2940

## CLIENT INTAKE FORM

| Client | | Today's Date |
|---|---|---|
| ❑ New ❑ Existing | | / / |

### CLIENT INFORMATION

| Last Name | First Name | Middle |
|---|---|---|
| | | |

| Home Address | Mailing Address |
|---|---|
| | |

| City | State | Zip Code | City | State | Zip Code |
|---|---|---|---|---|---|
| | | | | | |

| Identified Gender | Date Of Birth | Age | Social Security Number | Marital Status of Parents: (Circle One) |
|---|---|---|---|---|
| ❑ F ❑ M | / / | | | Single Married Divorced Separated Widowed |

### PARENT/GUARDIAN INFORMATION

| Home Phone | Cell Phone | Email Address | Work Phone | Ext. |
|---|---|---|---|---|
| ( ) | ( ) | | ( ) | |

| May we leave voicemail messages? | At Your Home: | ❑ Yes ❑ No | At Your Work: | ❑ Yes ❑ No |
|---|---|---|---|---|

### IN CASE OF EMERGENCY

| Emergency Contact | Home Phone | Work Phone | Ext. | Relationship To Patient |
|---|---|---|---|---|
| | ( ) | ( ) | | |

### EMPLOYMENT INFORMATION

Employment Status

❑ Full Time ❑ Part Time ❑ Not Employed ❑ Active Military ❑ Self Employed ❑ Retired ❑ Student ❑ Other:

| Occupation | Employer | Employer Phone |
|---|---|---|
| | | ( ) |

| Employer Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

### CLIENT PHYSICIAN INFORMATION

| Referring Physician | Primary Care Physician |
|---|---|

(Continued On Other Side)

| Name and address: | Name and address: |
|---|---|

## PRIMARY INSURANCE INFORMATION

| **Primary Insurance Company** | Group Number | Insurance Id. Number | Co-Pay |
|---|---|---|---|
| | | | |

Patient's Relationship To Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

**Subscriber Information**

| Last Name | First Name | Gender | | Date Of Birth | Employer |
|---|---|---|---|---|---|
| | | ❑ F | ❑ M | / / | |

## SECONDARY INSURANCE INFORMATION

| **Second Insurance Company** | Group Number | Insurance Id. Number | Co-Pay |
|---|---|---|---|
| | | | |

Patient's Relationship To Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

**Subscriber Information**

| Last Name | First Name | Gender | | Date Of Birth | Employer |
|---|---|---|---|---|---|
| | | ❑ F | ❑ M | / / | |

## FINANCIAL RESPONSIBILITY
**(If other than patient)**

| Last Name | First Name | Middle |
|---|---|---|
| | | |

| Mailing Address | Home Phone | Work Phone |
|---|---|---|
| | ( ) | ( ) |

| City | State | Zip Code | Relationship To Patient |
|---|---|---|---|
| | | | ❑ Parent ❑ Guardian ❑ Other: |

## FINANCIAL AGREEMENT — SIGNATURE REQUIRED

I understand that I am financially responsible for all charges rendered by Lysa Webb, MA LPC whether or not they are covered by insurance. I hereby give lifetime authorization for payment of insurance benefits directly to Lysa Webb, MA LPC accounts. I acknowledge that I am solely responsible in securing the necessary **REFERRALS** from my **PRIMARY CARE PHYSICIAN**. In the event of default I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I have read the above and additional FINANCIAL AGREEMENT and understand it.

**Signature** (Parent/Guardian signature- if client is a minor) **Date**