KITSAP COUNSELING SERVICES LLC
DIANE SABO, MA, LMCH

NEW CLIENT INTAKE FORM

Patient's Name: _____ Age: _____ DOB: _____

For Children/Adolescents – Parent's Name: _____

Address: _____

City, State, and Zip: _____

Work Phone: _____ Cell Phone: _____

Email address: _____

Employer: _____

Brief History of Presenting Problem:

_____

_____

AUTHORIZATION: I authorize the release of any information necessary to process insurance claim forms. I understand that I am responsible for any necessary insurance submitting.

I also understand that I may be charged a $25.00 fee for checks returned by my financial institution. I further understand that this account is my responsibility and that I must pay any amounts not covered by insurance, including, but not limited to, co-payments, missed appointments, late cancellations, etc. I understand that any unpaid balances that are more than 60 days past due will be referred to a third-party legal collection firm.

Signature: _____ Date: _____