Gateway Psychological Services, LLC

Individual Intake

Client's Full Name* : _____

Age * : _____ Today's Date * : _____

Birthdate * : _____ Home Phone * : _____

SSN# * : _____ Cell Phone : _____

Marital Status * : _____ Work Phone : _____

Address * : _____

_____

_____

City * : _____ State * : _____

Zip * : _____

Referred by : _____

Phone : _____

Employer or School (If Student) * : _____

Emergency Contact Name * : _____

Relationship * : _____

Phone * : _____

Gateway Psychological Services, LLC

Insurance Information

Insurance Company * : _____

Name of Insured * : _____

Insured's SSN # * : _____

Insured's DOB * : _____

Insured's Policy # * : _____

Insured's Group # * : _____

Insured's Employer * : _____

Amount of Copays * : _____

Insured's Relationship to Client * : _____

Authorization # * : _____

If your counseling is being paid for through an employee assistance program, please list authorization number and how many sessions are being authorized.

EAP Company: _____

Authorization #: _____

# of Sessions: _____

Have you called your insurance for pre-authorization? *

☐ Yes ☐ No

If yes, list pre-authorization # / Name: _____

View Required Forms

Gateway Psychological Services, LLC

By clicking below you are acknowledging that you have been provided with and accept the following: *

- [ ] Privacy Notice
- [ ] Confidentiality Policy
- [ ] Payment and Fee Information

Signature * : _____

Date *: _____