Oksana Heicklen
Licensed Marriage and Family Therapist
License # MFC 43656
760-805-4740

Date:_____

INTAKE INFORMATION

Client Name _____ DOB _____ Marital Status _____

Address _____ City/Zip_____

Phone _____ Cell Phone _____ Email Address _____

Type of Work _____ SS# (if using insurance) _____

Emergency Contact Name _____Phone # _____

Referral Source _____ Previous Counseling _____

CHILDREN	DOB
_____	_____
_____	_____
_____	_____

INSURANCE INFORMATION

Please provide copies of all Insurance ID cards, FRONT and BACK , if applicable

INSURANCE NAME _____

SUBSCRIBER'S NAME _____
SEX: M ___ F ___ DOB _____

SUBSCRIBER'S ID # _____

GROUP# _____

SUBSCRIBER'S EMPLOYER _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER:
SELF ___ SPOUSE ___ CHILD ___ OTHER ___

INFORMATION WE NEED FROM YOUR INSURANCE CO.

1. Are you covered for out-patient mental health services? _____
2. What is your co-payment? _____
3. Do you have a deductible? _____ Amount _____
4. How many sessions are you allowed per year? _____
5. How parity (severity) diagnosis effects above information?
_____
6. Do you need authorization for services? _____

You may want to call your insurance company for this information to be better aware of your benefits and to assure payments.