Lowry Hill Psychotherapy & Assessment Center

1910 Hennepin Avenue South
Minneapolis, MN 55403
Phone: (612) 871-2544
Fax: (612) 814-0668
Email: psychotherapy@lowryhillpac.com

Intake Paperwork

Name: ____ Date: _________
Address: ____
City/State: ____ Zip:__________
Sex: _______ Birth date: _________________ Phone Number: ____________________
Is it okay to leave a message at this number? Yes: _______ No: _______
Email: ____

Name of insurance Carriers:
Primary: ____
ID #: _______________________ Group #: ________________________
Secondary: ____
ID #: _______________________ Group #: ________________________
PLEASE INCLUDE COPY OF CLIENT'S INSURANCE CARD (FRONT & BACK)

Emergency Contact
Name: _____________________________
Phone: _____________________________
Relationship to you: __________________

What brings you in at this time?
____
____

List current partner, children, and/or others in your household:

Name	Gender	Current Age	Relationship to you

Do you ever feel unsafe in your current living situation? If so, please explain:
____
____

Describe your current health concerns (diet, exercise, sleep, chronic health problems, etc.)
____
____

Current Medications: ____
Date of last physical exam: __________________

AUTHORIZATION OF BENEFITS AND
AUTHORIZATION TO RELEASE INFORMATION

I authorize payment of my benefits to Lowry Hill Psychotherapy and Assessment Center for mental health and/or assessment services rendered. I understand that I will be responsible for any cost accrued which are not covered by my insurance company.

I also authorize the release of pertinent information (e.g. diagnosis) regarding these claims to my insurance company, as requested by the company. Payments should be mailed to:

Lowry Hill Psychotherapy and Assessment Center
1910 Hennepin Avenue South
Minneapolis, MN 55403

A photocopy or electronic version of this authorization shall be as valid as the original.

___________________________________ ___________________
Client's signature Date

____
Print Name

___________________________________ ___________________
Parent or Guardian (if applicable) Date

___________________________________ ___________________
Therapist's signature Date

Signatures page

____
Client's Printed Name

In the event of Emergency, I authorize an individual at Lowry Hill Psychotherapy and Assessment Center to call my emergency contact.

Client's signature	Date
Parent or Guardian (if applicable)	Date

My signature below indicates that I have read and understand the information in the policies and procedures document. I agree to abide by its terms while receiving services. I was given a copy of this document.

Client's signature	Date
Parent or Guardian (if applicable)	Date

My signature indicates that I understand my rights as a client and have been offered a copy of HIPPA regulations, the MN Psychologists Policies and Practices to protect the privacy of patient health information and the client bill of rights.

Client's signature	Date
Parent or Guardian (if applicable)	Date
Therapist's signature	Date