

Melanie Welch Counseling

505 Broadway St Lincoln, IL 62656
230 W Main St Decatur, IL 62523

217-828-1534
melaniewelchcounseling@gmail.com

Intake Form

Please complete and bring with you at the first appointment. If you do not feel comfortable with a question, please leave blank and bring to my attention at the first appointment.

Today's Date: ___/___/_____

Patient Information:

Name: (First)_____ (Middle Initial)_____ (Last) _____

Name you prefer to be called: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Cell: _____ Home: _____ Work: _____

Email address: _____

Age: _____ Date of Birth: ___/___/_____ Social Security Number: _____

Employer Name (if employed): _____ Occupation: _____

Billing Address: Same as above. If different, complete where you would like bills sent to:

Name: (First)_____ (Middle Initial)_____ (Last) _____

Address: _____ City: _____ State: _____ Zip: _____

In the event of an Emergency, whom should we contact?

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Method of Payment:

____ Insurance (See Below) ____ EAP (See Below) ____ Self Pay ____ Other

Who is the Insured Member if Not Patient:

Name : (First)_____ (Middle Initial)_____ (Last) _____

Relationship: _____

Address: _____

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Phone: Cell: _____ Home: _____ Work: _____

Date of Birth: ____/____/____ Social Security Number: _____

Employer Name: _____

If Payment is by Insurance, please complete the section below:

Name of Insurance company: _____

Insurance ID Number: _____

Group Name and Number: _____

Is Pre-Authorization Required: ___ No ___ Yes

If Payment is by Employee Assistance Program (EAP), please complete the section below:

Name of EAP: _____

Your EAP is through what Employer: _____

Authorization Number: _____

How many sessions do they allow? _____

Additional Information:

Your Primary Care Physician: _____

Physician Address: _____ Phone: _____

Who referred you to this office? _____

If self-referred, how did you learn about us? _____

May we call to remind you of your appointments? ___ Yes ___ No What Number? _____

Would you prefer a text reminder? ___ Yes ___ No What Number? _____

- By authorizing, you are aware texting appointment information is not HIPPA compliant

Please give 24 hour notice if you cannot keep this appointment. No shows will be billed \$25

Your Signature: _____ Date: _____