### Deanna Kozlowski, LISW

### 9 2nd Street NW, Mason City, IA 50401

### 641-530-4055

### INTAKE FORM

**Client Name** \_\_\_\_\_\_ Today’s Date

Date of Birth ­­­­­­­­­­­­­­­­\_\_\_\_\_\_

Address Home Phone \_\_\_\_\_

City State \_\_\_ Zip\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed by \_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (not living with client) Phone \_\_\_\_

**Family Physician** Allergies

Medications/Dosage

##### Insurance Information

##### Primary Insurance

Insurance Company Phone \_\_\_

Subscriber **Date of Birth** \_\_\_

ID Number \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

Address and Phone of Subscriber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance (if any)**

Insurance Company Phone \_\_\_\_

Subscriber \_\_\_ **Date of Birth**

ID Number

Address and Phone of Subscriber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Deanna Kozlowski, LISW to release medical information to my insurance carriers in order to process insurance claims.

I hereby authorize payment of medical insurance benefit to be paid directly to Deanna Kozlowski, LISW.

I understand that I am financially responsible for the payment of all charges rendered to me, or to any members of my family, and that payment is expected at the time services is rendered, regardless of any insurance coverage I may anticipate. I further understand that travel time from any school, home or other visit that my therapist makes at my request will be billed on the basis of my therapist’s regular rate.

I understand that there will be a charge for appointments not cancelled 24 hours in advance, unless the appointment time is filled.

I understand that should any legal action be necessary to collect any amounts owed by me, I will be responsible for any and all costs and attorney fees.

I have read and understand the above statements.

Signature Date