Embark Mental Health

3240 E Bison Trail, Suite 200
Sioux Falls, SD 57108
P: (605) 961-4746 **F:** (605) 961-4747

Health Intake Form

Please complete for person to be seen

Name: _____
First Middle Initial Last

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Gender: ☐ Male ☐ Female ☐ Other: _____ Student: ☐ Full time ☐ Part time

Employer: _____

Email Address: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

In case of emergency, person to contact (circle one): Spouse or Parent(s) or Other: _____

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance Information/Authorization:

Primary Insurance: _____

ID Number:_____

Group Number: _____

Embark Mental Health

3240 E Bison Trail, Suite 200
Sioux Falls, SD 57108
P: (605) 961-4746 **F:** (605) 961-4747

Name of Policy Holder: _____ Birth Date: _____

Relationship to Client: _____ Phone: _____

Address of Policy Holder: _____

City: _____ State: _____ Zip: _____

Employer of Policy Holder: _____

Secondary Insurance: _____

ID Number: _____ Group Number: _____

Name of Policy Holder: _____

I hereby authorize Embark Mental Health, LLC to release necessary information to insurance carriers concerning my diagnosis and treatment in order to process my claims. I hereby authorize direct payment to Embark Mental Health, LLC from insurance carriers for services rendered if my account is not paid in full. I permit a copy of this authorization to be used in place of the original copy.

Signature: _____

Please send the billing invoice to:

☐ Self ☐ Parent (name): _____ ☐ Other: _____

Credit Card Information:

Your information will be on file and be used in the case of a No Show or if the appointment is cancelled with less than 24 hour notice, per our policy. Your signature also gives permission to keep your information on file to charge your card for co-pays or payments.

Name on Card: _____ Type: _____

Number: _____ Expiration Date: _____

CVV: _____ Billing Zip Code: _____ SSN# (responsible party): _____

Signature: _____ Date: _____

Embark Mental Health

3240 E Bison Trail, Suite 200
Sioux Falls, SD 57108
P: (605) 961-4746 **F:** (605) 961-4747

Health Information of Client:

Present health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Significant health concerns: _____

Current medications:

Drug/Dosage: _____ Drug/Dosage: _____

Drug/Dosage: _____ Drug/Dosage: _____

Do you smoke?: ☐ Yes ☐ No Packs/Day/Longevity: _____

Do you use alcoholic beverages?: ☐ Yes ☐ No If so, how often?: _____

Physician Information/Authorization:

I hereby authorize Embark Mental Health, LLC to release records and/or information about my treatment to my physician for the purpose of treatment, planning, and coordinating psychotherapy with my physical health care needs. I may withdraw this consent at any time in writing or verbally advising my therapist.

Physician: _____ Clinic: _____

Signature of Client: _____ Date: _____

Signature of Parent or Guardian (if applicable): _____ Date: _____

Client's Intake Questionnaire

What are your concerns that you want to address in counseling?

_____

_____

What are your goals for counseling?

_____

_____

How did you hear about us? _____