CLIENT INFORMATION & INTAKE FORM

Discovery Cove Recovery and Wellness Center, LLC
11901 Business Blvd, Suite 201 Eagle River, AK 99577
Phone: (907) 694-5550 * Fax: (907) 694-5570

CONFIDENTIAL

Intake Date	**Intake conducted by:**	
GENERAL INFORMATION (Please PRINT clearly)		
Client's Name:		**Date of Birth:**
Mailing Address: (Include Street, City, State, and Zip Code)	**Email:**	
Phone Numbers (Please **circle main** phone number**)** **Home**: **Work**: **Cell**:		
Marital Status: (Please circle) Single Married Divorced / Separated Other		**Sex: (Please Circle) Male Female**
S.S. Number:	**Driver's License:**	
Who to Notify in Case of Emergency:	**Relationship to Client:**	**Emergency Contact's Address and Phone Number:**
How did you did you become aware of this counseling service?		
EMPLOYER INFORMATON FOR RESPONSIBLE PARTY		
Employer's Name:	**Your Occupation:**	
Employer's Address :(Include Street, City, State, and Zip Code)		
Employer's Phone Number:		
SELF PAY ☐		
Responsible party:	**Relationship to client:**	
Address (include street, city, state, and zip code)		
Phone Numbers (include home, work, and cellular):		
Social Security Number:	**DOB:**	**Driver's License:**

INSURANCE ☐			
Primary Insurance Name	**ID #:**	**Group #:**	**Plan Name:**
Primary Policy Holder's Name:	**Primary Policy Holder's SSN:**	**Primary Policy Holder's DOB:**	
Primary Policy Holder's Address (include street, city, state, and zip code)			
Primary Policy Holder's Phone Number:	**Primary Insurance Co. Phone Number:**		
Secondary Insurance Name	**ID #:**	**Group #:**	**Plan Name:**
Secondary Policy Holder's Name:	**Secondary Policy Holder's SSN:**	**Secondary Policy Holder's DOB:**	
Secondary Policy Holder's Address (include street, city, state, and zip code)			
Secondary Policy Holder's Phone Number:	**Secondary Insurance Co. Phone Number:**		

PLEASE SIGN AND RETURN

I, undersigned, have insurance coverage with _____ and assign directly to Discovery Cove Recovery and Wellness Center/Ken McCarty, LMFT all mental health benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the therapist to release information necessary to secure the payment benefits.

Signed:_____Date:_____