



Two Roads Counselling

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Coleman, Alberta
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connie@tworoadscounselling.com

Client Intake Form

Intake Form

Please take your time in filling out this form. If any areas do not apply to you, you do not need to answer them.

Contact Details

First Name

Last Name

Preferred Name

Date of Birth (YYYY-MM-DD)

Gender Identity

Pronoun

Email

Home Phone

Mobile Phone

Email Reminders *(Select only one)*

- None
- 2 hours before appointment
- 4 hours before appointment
- 6 hours before appointment
- 8 hours before appointment
- 12 hours before appointment
- 24 hours before appointment
- 48 hours before appointment
- 72 hours before appointment
- 96 hours before appointment

SMS Reminders *(Select only one)*

- None
- 2 hours before appointment
- 4 hours before appointment
- 6 hours before appointment
- 8 hours before appointment
- 12 hours before appointment
- 24 hours before appointment
- 48 hours before appointment
- 72 hours before appointment
- 96 hours before appointment

Address

Street Address

City

Postal Code

Emergency Contact

Name

Phone

Email

Relationship *(Select only one)*

- Dependant
- Other
- Parent
- Spouse
- Partner
- Sibling

- Student
- Doctor
- Lawyer
- Teacher
- Third-Party

Insurance

Primary Insurance Company:

Phone Number:

Insured Name:

Date of Birth: (YYYY-MM-DD)

Member ID#:

Group #:

Employer:

Authorization #: (if required by insurance company):

Secondary Insurance Company (if applicable):

Phone Number:

Insured Name:

Date of Birth: (YYYY-MM-DD)

Member ID#:

Group #:

Employer:

Authorization # (if required by insurance company):

I understand that I am responsible for payment to Two Roads Counselling for any amounts payable that are not covered by my insurance provider.

Approval and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes. I authorize such insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits, or other benefits programs, other organizations, or service providers working with such insurer and/or plan administrator or any of the foregoing, when relevant for the above purposes.
- where applicable exchange personal information concerning any claims with any assignee of benefits payable and exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law. I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my employer or benefit plan sponsor, for the purposes of investigation and prevention of fraud and/or benefit plan abuse.

I understand that the submission of fraudulent claims is a criminal offence. If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my benefit plan sponsor, for that purpose.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/or plan administrator and their service provider(s) to use and disclose their personal information as set out above.

I agree to the terms outlined in this form.