Chelsea Williamson, M.A.,

Licensed Marriage and Family Therapist #105402

1650 Oregon St. Suite 207

Redding, Ca. 96001

Phone: 530-515-7551

New Client Intake

Contact Information		
Name:		Date of Birth:
Phone Number: ( )		
Physical Address:		
Mailing Address (if different):		
Gender:	Marital Status:	Client SSN:
Spouse/Partner's Name:		
Spouse/Partner's Phone Number: ( )		

Consent for Treatment of a Minor

If the student is under 18 years of age, I require written permission to provide counseling sessions. If the parents of the student **are divorced or legally separated**, and share **legal** custody of the child, we are **legally required** to obtain **BOTH** parents' permission to treat the student.

Parent/Guardian Name (**print**):_____

Parent/Guardian Name (**sign**):_____

Date: _____

- Please check **one**: ☐ I have **full legal** custody ☐ I have **joint legal** custody

Parent/Guardian Name (**print**):_____

Parent/Guardian Name (**sign**):_____

Date: _____

Chelsea Williamson, M.A.,

Licensed Marriage and Family Therapist #105402

1650 Oregon St. Suite 207

Redding, Ca. 96001

Phone: 530-515-7551

Billing/Insurance Information		
Primary Insured Name:		
Primary Insured SSN:	Primary Insured DOB:	
Primary Insured Employer:		
Primary Insured Relationship to Client:		
Name of Insurance:	Customer Service #:	
Insurance ID #:	Group #:	

Victim Witness	
Claim #:	
Do you have private insurance?	If YES, please provide information above.
Name of Victim:	Relationship to Victim:
Name of Advocate at Victim Witness:	

Insurance Certification and Assignment: I hereby certify that the information given to me in applying for payment under the title XIX of the Social Security Act, by insurers, or by any other third party is correct. I assign payment to the provider rendering medical service to the client. I understand that I am responsible for payment of any health insurance deductible(s), co-insurance, or any other charges incurred which are not paid by any insurance of third party payers.

Release of Information: I hereby authorize my psychotherapist, physician, hospital, pharmacy, insurance company, employer or organization responsible for payment of this claim or to any physician or health service provider who will render care to the client after discharge:

I understand that all the charges incurred are my responsibility, regardless of insurance coverage or third party agency. For collection I agree to pay all reasonable court costs and collection fees. I understand that all judgments in a court of law may bear interest at the legal rate.

Client/Guardian/Responsible Party Signature: _____

Date: _____