

Integrating Mind, Body, Spirit and Community

MIRACLES, INC HEALING CENTER

134 PROFESSIONAL PARK DRIVE, SUITE 400

MOORESVILLE, N.C. 28117

704-664-1009 Fax: 704-664-1029

We are so glad you are here!

Provider (Therapist)

Name: _____ **Date:** _____

INDIVIDUAL INTAKE

Clients full name:

Address: _____ **City** _____ **State** _____ **Zip** _____

Telephone:Hm: _____ **Cell:** _____ **Work:** _____

Birthdate: _____ **SS#:** _____ **DL#:** _____

Emergency contact:

Name: _____ **Telephone:** _____

Employer or School: _____

Part time or Full time: _____

**Employer or
School address:** _____

Referred by: _____

Email address: _____

INSURANCE INFORMATION

Insurance Company: _____ **Policy**
holder: _____

Relationship to insured: _____ **Insured's**
D.O.B.: _____

Policy #: _____ **Group #:** _____ **Insured's**
S.S.#: _____

Co Pay amount: _____ **Deduc.** _____ **Insured's Employer**
name: _____

Insured's Employer's
address: _____

Secondary
Insurance: _____ **Group#:** _____ **Policy#** _____

Medicaid/Medicare?: _____

If yes, Physician NPI: _____ **Auth #** _____

IF YOUR COUNSELING IS BEING PAID FOR THROUGH AN EMPLOYEE ASSISTANCE PROGRAM, PLEASE LIST AUTHORIZATION NUMBER AND THE NUMBER OF SESSIONS AUTHORIZED.

Eap Company: _____

Authorization Number: _____ **# of sessions:** _____

TO BE COMPLETED BY THERAPIST:

Procedure Code: _____ **Primary DX code:** _____ **Secondary DX code:** _____

AxisIII: _____ **AxisIV:** _____ **AxisV:** _____ **Current**

GAF: _____

Breathe into your belly and be the Miracle that you are!