Mary H. Fimbres, MSW, ACSW, LCSW DX Code:
The Atrium At Arrowhead
17505 N. 79th Ave.; #304-B
Glendale, Arizona 85308
phone: 623-937-3556 fax: 623-937-3557
MaryHFimbres.com

INTAKE FORM

Please complete BOTH PAGES of this CONFIDENTIAL Client Information Form as thoroughly as possible. Forms for children MUST be completed by a parent or guardian.

Client

(This is the primary person who will be seen by Mary H. Fimbres)

Client Name _____ Date of Birth _____ Age _____
Identified Gender (please circle) Male Female Non-binary

Relationship _____ Social Security Number _____
(required for adults)
Address _____ Referring Provider _____

City _____ State _____ Zip _____ Home phone ( ) _____
Cell phone ( ) _____
Marital Status (circle): single married other Work phone ( ) _____

Employment Status (please circle) full time part time student retired other

Notify in emergency: Name _____ Phone ( ) _____

Insured

(The following is information about the EMPLOYEE or INSURED with the insurance benefit)

Name of Employee _____ Date of Birth _____ Age _____
Identified Gender (please circle) Male Female Non-binary

Social Security Number (required) _____ Home / Cell ( ) _____
Work phone ( ) _____
Employer _____
Full Time / Part Time Hire Date _____ Job Title _____

Insurance Information: PRIMARY

Private Pay: Yes / No (amount) _____ Authorization # _____

Details _____ Deductible: Yes / No (Amount) _____

Copay _____ Number Of Visits Authorized _____

Employee Assistance Program: Yes / No EAP Name _____

Primary Insurance Carrier _____

Address _____

Phone ( ) _____ Policy Holder Name _____

ID Number _____ Group Number _____

Other Insurance

Name of Insured _____ Date of Birth _____ Age _____
Identified Gender (please circle) Male Female Non-binary

Social Security Number (required) _____ Home / Cell ( ) _____

Employer _____ Work phone ( ) _____

Full Time / Part Time Hire Date _____ Job Title _____

Primary Insurance Carrier _____

Address _____

Phone ( ) _____ Policy Holder Name _____

ID Number _____ Group Number _____

Reason For Today's Visit

Is it related to: employment: y / n auto accident: y / n other accident: y / n

Please state the reason for today's visit: _____

Assignment Of Benefits / Release Of Information / Privacy Policy

I hereby authorize direct payment of all benefits to Mary H. Fimbres, LCSW, including my benefits otherwise payable to me. This agreement shall remain in full force and effect until written notice to the contrary is provided by the undersigned. I hereby acknowledge that I will be personally responsible for payment of assigned insurance benefits when not paid within sixty (60) days of filing a completed claim and when adequate information to determine whether the insurance will pay the charges is unavailable.

I authorize release of any medical or other information necessary to process this claim.

I acknowledge that I have read the privacy policies of Mary H. Fimbres.

_____ _____
Insured or Responsible Party Date

_____ _____
Witness Date