



**Tangletown Psychotherapy  
&  
Assessment Center**

6 East Diamond Lake Road  
Minneapolis, MN 55419  
Phone: (612) 823-5178  
Fax: (612) 814-0668  
Email:  
psychotherapy@tangletownpac.com

**Intake Paperwork**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Sex: \_\_\_\_\_ Birth date: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Is it okay to leave a message at this number? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
Email: \_\_\_\_\_

Name of insurance Carriers:

Primary: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Secondary: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

PLEASE INCLUDE COPY OF CLIENT'S INSURANCE CARD (FRONT & BACK)

Emergency Contact

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_

What brings you in at this time?

\_\_\_\_\_  
\_\_\_\_\_

List current partner, children, and/or others in your household:

Name	Gender	Current Age	Relationship to you

Do you ever feel unsafe in your current living situation? If so, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Describe your current health concerns (diet, exercise, sleep, chronic health problems, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Current Medications: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

**AUTHORIZATION OF BENEFITS AND**  
**AUTHORIZATION TO RELEASE INFORMATION**

I authorize payment of my benefits to Tangletown Psychotherapy and Assessment Center for mental health and/or assessment services rendered. I understand that I will be responsible for any cost accrued which are not covered by my insurance company.

I also authorize the release of pertinent information (e.g. diagnosis) regarding these claims to my insurance company, as requested by the company. Payments should be mailed to:

Tangletown Psychotherapy and Assessment Center  
6 East Diamond Lake Road  
Minneapolis, MN 55419

A photocopy or electronic version of this authorization shall be as valid as the original.

\_\_\_\_\_  
Client's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parent or Guardian (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's signature

\_\_\_\_\_  
Date

Signatures page

\_\_\_\_\_  
Client's Printed Name

**In the event of Emergency, I authorize an individual at Tangletown Psychotherapy and Assessment Center to call my emergency contact.**

\_\_\_\_\_  
Client's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian (if applicable)

\_\_\_\_\_  
Date

**My signature below indicates that I have read and understand the information in the policies and procedures document. I agree to abide by its terms while receiving services. I was given a copy of this document.**

\_\_\_\_\_  
Client's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian (if applicable)

\_\_\_\_\_  
Date

**My signature indicates that I understand my rights as a client and have been offered a copy of HIPPA regulations, the MN Psychologists Policies and Practices to protect the privacy of patient health information and the client bill of rights.**

\_\_\_\_\_  
Client's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's signature

\_\_\_\_\_  
Date