

Request for an Appointment

Counseling, Psychological Testing & Psychiatric Clinical Services

Following is information that may be helpful before completing an appointment request:

- Intuition Wellness Center’s clinical team provides counseling services for individuals ages 3 - 25 and their family members. Psychological testing is available for ages 6 - 25, and psychiatric clinical services are offered for individuals ages 5 and older.
- Some counseling services may be billable to Blue Cross Blue Shield and Aetna insurances. Please contact your insurance provider to verify your specific plan benefits. [View pricing information.](#)
- Intuition Wellness Center’s training team provides services at a reduced fee, which are not typically billable to insurance. [View benefits to working with our training department.](#)
- Availability and specialty vary per clinician. Your flexibility with scheduling team member preference will improve the team’s ability to serve you.
- **Note:** The Intuition Wellness team values a thoughtful match process. It may take approximately 10 business days for the team to formulate a response to your request. Thank you for your patience.

The questionnaire below is required in order to determine Intuition Wellness Center’s ability to meet your needs for counseling, psychological testing and psychiatric clinical services. Please call 520-333-3320 if you have any questions.

If you are submitting a request for multiple people, please fill out a separate form for each person.

Date: (required)* _____

Your Name: (required)* _____

Your Email: (required)* _____

Your Phone: (required)* _____

Would you like to sign up to receive our emailed parenting tips? (required)*

Yes No

Who are you seeking services for? (required)*

Self Child Family

If seeking services for someone other than yourself, what is their name? (required)*

Sex assigned at birth of prospective client: (required)*

Male Female Other

Date of birth of prospective client: (MM/DD/YYYY; required)* _____

If prospective client is a child, what school do they attend? (required)* _____

School grade: (required)* _____

How did you hear about Intuition Wellness Center? (required)*

- BCBS Aetna Psychology Today
- Internet (e.g., Google) PCP Other Professional Other

Please expand on who or where: (required)* _____

Do you have a team member preference? (Select ALL that apply; required)*

Your flexibility increases the chance of a successful match. [View benefits to working with our training team.](#)

- Any Licensed Team Member
- Supervised Doctoral Student or Clinician Pursuing Higher Licensure
- Psychiatric Nurse Practitioner
- Specific Team Member

Name of specific team member: _____

What service(s) are you requesting? (Select ALL that apply; required)*

- Counseling Play Therapy Parent Guidance Family Therapy
- School Success Consultation Psychological Testing Psychiatric Clinical Services

Please describe your concerns in just a few sentences: (required)*

Is the prospective client seeking treatment for the following? (required)*

- Eating Disorder Addiction None of these

If so, please provide a little more detail:

Does prospective client have a history of chronic substance abuse? (required)*

- Yes No

If so, please provide a little more detail:

Did prospective client recently attempt suicide? (required)*

Yes No

If so, how recently? _____

Is prospective client currently suicidal? (required)* _____

Yes No

If so, please call 9-1-1 or the crisis line at 866-495-6735 to speak to a crisis counselor.

Does the prospective client have a history of aggression or violence or are they currently aggressive or violent? (required)*

Yes No

If so, please provide a little more detail:

Did prospective client recently attempt homicide? (required)*

Yes No

If so, how recently? _____

Is prospective client currently homicidal? (required)*

Yes No

If so, please call 9-1-1 or the crisis line at 866-495-6735 to speak to a crisis counselor.

Has the prospective client had any past or current legal involvement, including parental divorce proceedings or Department of Child Services (DCS/CPS)? (required)*

Yes No

If Yes, please specify:

If requesting services for a child, are both parents available to consent to treatment? (required)*

Yes No N/A, prospective client is an adult

If No, please provide a little more detail:

If requesting services for a child, has either parent's rights been legally terminated? (required)*

Yes No N/A, prospective client is an adult

If Yes, please provide a little more detail:

Who has the power to make medical decisions for the prospective client according to the law?
(required)*

Please supply supporting court documents at intake or scan and email them to contact@intuitionwellness.com prior to your intake appointment.

Does prospective client have a previous treatment history? (required)*

Medical Behavioral Health Other None

Please provide a little more detail:

If you have previous behavioral health or medical treatment history, please bring a copy of records (e.g., treatment summary, treatment plan, testing reports, etc.) at the initial intake appointment.

How are you able to pay for services? (Select ALL that apply; required)* [View pricing information.](#)

Self Pay (Licensed Team Member) Self Pay (Training Department Reduced Fees)
BCBS Aetna

Note: Availability with insurance-accepting practitioners is limited.

Insurance ID: _____

Group #: _____

Subscriber Name: _____

Subscriber Date of Birth (MM/DD/YYYY): _____

Thank you for your interest in Intuition Wellness Center.

Please email the completed form to contact@intuitionwellness.com.