Client Information

First Name Middle Last Date of Birth(MM/DD/YYY)

Address City State Zip Code

Preferred Language:_____ SSN:_____
Emergency Contact:_____ Phone:_____
Primary Care Provider:_____ Phone: _____
Employer/School: _____
How did you hear about us?
_____
_____

Financial Information (Person responsible for payment)

First Name Middle Last Date of Birth (MM/DD/YYYY)

Address (If different from above) City State Zip Code

Phone Number:_____
Can we leave messages? _____
Email address:_____
Could we send emails to the address above? _____

Insurance Clients:

Insurance Carrier:_____ Group #:_____
Subscriber Name:_____ID #:_____
EAP?_____
Number of Covered Sessions:_____

Self-Pay Clients

I, _____ am fully responsible for each payment at the time of the visit. Payments will made before my session begins with my therapist.

I agree to the payment amount of: _____ for continuing mental health counseling services for the time period of_____ with review on _____.
With the authorization of: _____ Date:_____
Client Consent: _____ Date:_____