

CLIENT INFORMATION

(Please Print Clearly)

Client Name: _____
Last First Date of Birth: (MM/DD/YYYY) Age

Partner Name: _____

Parent(s) Name (for minor child only): _____

Address: _____
City State Zip

Employer: _____ Occupation: _____

School: _____ Grade: _____

I wish to be contacted in the following manner (check all that may apply):

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone: _____ | <input type="checkbox"/> Work Telephone: _____ |
| <input type="checkbox"/> O.K. to leave a message with detailed information | <input type="checkbox"/> O.K. to leave a message with detailed information |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Leave message with call-back number only |

I give legal permission to contact another individual at the following phone number(s):

Name(s) of other contact(s): _____ Relationship: _____

Home: _____ Work: _____ Mobile: _____

Signature of Responsible Party: _____

FINANCIAL RESPONSIBILITY

Name: _____
Last First Relationship

Address: _____
City State Zip

Phone: _____
Home Work Mobile

Social Security Number: _____
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I accept full responsibility for all fees due to professional services. I realize that any third party billing is out of courtesy to me and does not transfer any financial responsibilities for unpaid services.

I understand that 24 hours notice is required to cancel or change an appointment, and that if 24 hours notice is not given, I am responsible to pay a cancellation charge of \$60.00.

Signature of Responsible Party: _____ **Date:** _____

INSURANCE INFORMATION

*Your counselor may not have a contract with your insurance program. Do not assume your services are covered without first consulting with your counselor.

Name of Insured: _____

DOB: _____ SSN# _____

Employer: _____ Relationship to Client: _____

Insurance Company: _____

Insurance ID#: _____ Group #: _____

IN CASE OF EMERGENCY

Nearest Relative

Name: _____
Last First Relationship

Phone: _____
Home Work Mobile

REASON FOR COUNSELING

How did you hear about us? _____

Were you referred? Circle YES or NO If so, who referred you? _____

Have you ever received psychiatric or psychological help or counseling of any kind? If so, please explain: _____

MEDICATIONS or MEDICAL PROBLEMS
