PATIENT NO: ___________________

TODAY'S DATE:

CLIENT INFORMATION

Patient Name: ____ Date of Birth: __________________

Full Address _______________________________________ City ____________ Zip _____________

Gender: ___________ Marital Status: __________________ Home Phone#: _________________

Cell Phone#: _________________________ email: ____

Emergency Contact Name & Number & Relationship: ____

Yearly Household Income, Gross (before taxes) ____

If under 18, please provide parent/guardian contact information:

Parent/Guardian Name: ____________________________ Phone#: ____________________

Address, if different: ____

FINANCIAL RESPONSIBILITY

NAME: ______________________________________ RELATIONSHIP TO PATIENT: ___________

ADDRESS: __________________________________ CITY _______________ZIP________________

HOME PHONE#: ________________________ CELL PHONE#_________________________

If you are under the care of a physician, psychiatrist, or other medical professional who is providing medication and/or counseling:

Physician: ____________________________ Psychiatrist: __________________________

Phone: ____________________________ Phone: __________________________

Other Mental Health Professional: ____

Phone: ____

Please list currently prescribed Medications: ____

Signature of patient or parent/guardian: ____

RELEASE OF INFORMATION

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

Signature of patient or parent/guardian____

I authorize payment of medical benefits directly to the provider:

Signature of patient or parent/guardian____

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For Office Use Only

Therapist: ________________________________ DX Code 1: ___________

INSURANCE INFORMATION

Insurance Carrier: ____

Insurance Carrier Phone Number for verification of coverage: ____________________

Employer's Name: ____

Insurance I.D./Member I.D.: ____________________ **Group# ______________**

Member Name: ________________________ **Member DOB: ____________**

Member address, if different: ______________________________________

Member's phone#, if different: ______________________________________

Relationship to Patient: ____ Self ____ Spouse ____ Child ____ Guardian

Who may we thank for recommending you? ______________________________