Counselor:_____

ADULT CLIENT INFORMATION FORM

Diag. Code:_____

(PLEASE PRINT NEATLY and COMPLETE ALL SPACES)

Client Name: _____ Date: _____
First *Last* *MI.*

Street Address: _____

City:_____ State: _____ Zip: _____

Home #: (____)_____ Cell #: (____)_____ Marital Status: _____

Message may be left on phones – yes _____ no _____ Comments: _____

E-mail: _____ Preferred contact method: _____

Sex: Male _____ Female _____ Social Security #_____ - _____ - _____ Birthdate: _____ / _____/ _____

Name of Employer: _____

Employer Address: _____
Street Address *City* *State* *Zip*

Employer Phone #: (____)_____

Full-time student? _____(yes) _____(no)

Please tell us how you were referred to our office: _____

Previous Therapist Name: _____ Phone #: (____)_____

POLICY HOLDER'S INSURANCE INFORMATION

____ No insurance coverage

PRIMARY INSURANCE:

Name of Policy Holder: _____ Birthdate: _____ / _____/ _____
First *Last* *MI.*

Policy Holder's S.S. #_____ - _____ - _____ Policy / Member ID#:_____

Policy Holder's Employer: _____ Phone #: (____)_____

Insurance Company Name: _____

Insurance Company Address: _____
Street Address *City* *State* *Zip*

Insurance Company Phone #: (_____)_____ Group #: _____

FILING FOR SECONDARY INSURANCE IS THE CLIENT'S RESPONSIBILITY

CONSENT AGREEMENT:

Your insurance coverage is an agreement between you and your insurance company. You are the one responsible for your account. We will be happy to file claims for you. However, if your insurance does not pay its portion within the 6 weeks of the filing date, you are responsible for your bill. Any money received from your insurance company after you have paid us will be promptly refunded to you.

I hereby authorize Associates in Professional Counseling to release any information required in the clinical Supervision/Consultation and processing of claims.

I understand there will be a minimum $50.00 charge for failed appointments or cancellations less than 24 hours before my appointment. There will be a $20.00 charge for returned checks.

I acknowledge receipt of the Associates in Professional Counseling Privacy Notification and General Policy Statement.

X_____ **X**_____
Signature **Date**

P***AYMENT DUE UPON SERVICES RENDERED***

05/19