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Client Background Information

This information is kept in the strictest confidence and is used to facilitate counseling services and billing efficiency. Please fill this out, read and sign the attached Agreement, and keep a copy for your records.

Name of client:_____Birthdate:_____Today's date:_____

Street address:_____City:_____ Zip:_____

For children and teens, name of parent:_____Birthdate_____

Phone: (day)_____(eve)_____email:_____

Can leave messages at above numbers or email:____Referred by:_____

Reason for referral or problem:_____

_____Physician:_____

Current diagnoses:_____

Medications client is taking:_____

Billing/Insurance Information

Insurance Co. Name:_____ Phone:_____

Insurance billing address:_____

Policy holder (please identify by name):_____ ID number:_____

Policy holder's birthdate: _____Policy holder's group number:____ _____

Exclusions in policy (Family counseling, etc):_____ Is your deductible satisfied (if applicable)?_____. Approximate amount remaining:_____.

Thank you!