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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 Professional Disclosure 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: (cell) _____ (other) _____ email: _____

Can leave messages at above numbers or email? Yes: ☐ No: ☐
Referred by: _____

Reason for visit today: _____

_____

Current diagnoses/physician: _____

Medications client is taking: _____

Insurance Billing Information

Primary Insurance: _____ 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: _____

Secondary Insurance Payer (if applicable): _____ 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: _____