

OFFICE USE ONLY

Initials _____
Dx _____ F: _____
Add'l Info _____

INFORMATION SHEET*

Name & Address of Client: _____
(name) (street address)

Phone#: (____) _____
(city) (state) (zip) (home)

Phone#: (____) _____ Phone#: (____) _____
work cell/pager

SS# _____ Birthday: _____ E-Mail: _____

Occupation: _____ Employer _____

Payment and Insurance Information

Name & Address of Person or Org. Responsible for Payment: _____

SS# _____ Driver's License #: _____

Policy Holder: _____ Occupation: _____

Phone# (if different): _____ Birthday: _____

Health Insurance Company: _____ Employer _____

Insurance Policy#: _____ GRP# _____

Spouse Name: _____ Date Married: _____ Date of Previous Marriage: _____

Children/ Siblings (Names, Sex, B-day): _____

Family Physician: _____ Other Physician: _____

Recent/ Current Medical Problems _____

*** PLEASE TURN OVER FOR MORE INFORMATION**

Financial Policy: A charge will be made for missed appointments not cancelled at least 24 hours in advance. Sessions are 45-50 min. in length. Half sessions are 20-25 min; quarter sessions are 12-15 min. Payment is expected at time of service. Regardless of insurance, client is ultimately responsible for balances due to the Family Counseling Center for professional services rendered. I have understood the above policy.

Signature _____ Date _____

We are not able to bill insurances, with select few exceptions. We will provide you with all the necessary information you will need in order to bill your insurance company directly. Payment for services is expected at the time you are seen.

Current Medications (Type, Amt., Frequency) _____

Church Affiliation _____ Who Referred You To Us? _____

Previous Counseling:

Counselor	Date Began	Date Ended	Reason For Seeking Help	Reason For Ending

Please Describe Concerns That You Would Like Help With:

I will know that counseling has been helpful when (please finish):
