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(Please Print)

Please check all relevant boxes

Today's Date _____/_____/_____

CLIENT INFORMATION

Client's Last Name	**First**	**Middle**	❑ **Mr.** ❑ **Ms.**	**Marital Status (Circle One)** **Single / Married / Divorced / other**

Is this your legal name? ❑ **Yes** ❑ **No**	**If not, what is your legal name?**	(Former Name)	**Birth Date** / /	**Age**	**Sex** ❑ **M** ❑ **F**

Street Address	**City**	**State**	**ZIP Code**	Social Security - -	Home Phone No. ( )

P.O. Box	**City**	**State**	**ZIP Code**	**Cell Phone No.** **( )**

Occupation	**Employer**	**Work Phone No.** **( )**

Referred to Provider by (Please check one box & list) ❑ **Dr.** _____ ❑ **Insurance Plan** ❑ **Website**

❑ **Family** ❑ **Friend** ❑ **Close to Home/Work** ❑ **Yellow Pages** ❑ **Other** _____

Email Address:	**Alternative Email Address:**

PAYMENT INFORMATION

Insured's name if different from client	**Birth Date** / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? _____

What is exact name of insurance?	

What is the authorization number?	What is coinsurance %? _____	❑ **Self Pay**	❑ **I choose to not have an electronic record kept if I self pay**

Is there a Deductible?	**# of sessions allowed per calendar year?** ____	SS # / /	Group #	Policy #	**Co-Payment** $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Client / Parent Signature **Date**