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DATE _____ THERAPIST _____

NAME _____ BIRTHDATE _____

ADDRESS _____ SS# _____

CITY _____ STATE / ZIP _____

EMAIL _____ HOME PHONE _____

CELL PHONE _____ WORK PHONE _____

_____Married _____Widowed _____Divorced _____Separated _____Single

Spouse _____ Birthdate _____ Sex _____

Children _____ Birthdate _____ Sex _____

Children _____ Birthdate _____ Sex _____

Children _____ Birthdate _____ Sex _____

Reasons for Counseling

We are happy to bill your insurance as a courtesy to you - but payment for services is the sole responsibility of the client, and is expected at time of service unless prior arrangements have been made with your therapist. Because coverages and reimbursement procedures for mental heath services differ significantly from other medical services *your* coverage, deductible, and co-pay must be verified with your insurance carrier before we can accept an assignment of benefits as full or partial payment.
I have attached a copy of my insurance information if applicable

Signature of Client or Responsible Party _____