

Client Information Form

Counseling Center at the Crossing, Inc.

It is very important that you give as much information as possible.

Client Number (Office Use Only) _____

Therapist _____

Date _____

Client Information:

Last Name		First Name		Middle Initial	
Street					
City		State		Zip Code	
Home Phone ()		Cell Phone ()			
Sex (Circle One) M F	Date of Birth	Email Address			
Status (circle all that apply)					
Single	Married	Separated	Divorced	Employed	Full-time student Part-time student

Employment

Name of Employer		
Phone Number ()	Extension (if necessary)	
Address		
City	State	Zip Code

Responsible Party (the person responsible for charges; if client is a child, this would be the custodial adult or guardian)

Last Name		First		Middle	
Street					
City		State		Zip Code	
Home Phone ()		Work Phone ()		Cell Phone ()	
Date of Birth		Sex (Circle One) M F			
Email Address		Relationship to Client (circle one) parent spouse guardian other:			

COMMUNICATION CLEARANCE (Circle)

Telephone: Home / Cell Y N Text / Email Y N Work Y N Mail to Home: Y N

Nearest Relative (Not living in household)

Last Name		First		Middle	
Street					
City		State		Zip Code	
Relationship		Phone Number ()			

Family Members Living in Household (Continue on back, if necessary)

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral Information (How were you referred to the Counseling Center at the Crossing, Inc.? (Circle One)

Brochure	New Life	Counseling Center Client
Minister	Friend	Website/Internet
Church	Family	Phone book/Yellow Pages
School	Focus on the Family	Other _____

Name of Referring Person _____

I consent to have the counselor contact the referring person to let him/her know that I have begun counseling.

Signature: _____

Date: _____

Please circle church denomination

Baptist	Assembly of God	Presbyterian	Church of Christ	Church of God
Catholic	Episcopal	Lutheran	Christian Church	Non-denominational
United Methodist	Evangelical Free	Wesleyan	Disciples of Christ	No church affiliation
Other _____				

Local Church Attended

The following information **MUST BE COMPLETED IN FULL** for claims to be correctly submitted.

Primary Insurance

Insurance Company	Policy Holder Name	Policy Holder's Date of Birth
ID Number (or Social Security Number)	Group Number	Employer of Policy Holder
Insurance Company Address	Insurance Company Phone Number ()	
Policy Holder Address (if different from Client or Responsible party)	Home Phone Number	Work Phone
Client relationship to Policy Holder (circle one): self spouse child		

Secondary Insurance

Insurance Company	Policy Holder Name	Policy Holder's Date of Birth
ID Number (usually Social Security Number)	Group Number	Employer of Policy Holder
Insurance Company Address	Insurance Company Phone Number ()	
Policy Holder Address (if different from Client or Responsible Party)	Home Phone Number	Work Phone
Client relationship to Policy Holder (circle one): self spouse child		

Client's Authorization to Release Medical Information and for Claim Payment

I hereby authorize my health care provider to release information to my insurance company regarding services rendered by him/her.

Date: _____ Signature: _____

I hereby authorize and direct my insurer to issue payment check(s) for benefits due me for the services rendered by my health care provider to be made directly to Counseling Center at the Crossing, Inc. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered. I shall be responsible for all fees incurred for service provided to my dependents. I further acknowledge I will be responsible for reasonable collection fees, attorney's fees and court costs incurred in any attempt by the provider to collect amounts I may owe.

Date _____ Signature _____