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 ( )

Date of Birth Social Security Number Sex (Circle One) **M F**

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 ( )

Date of Birth Sex (Circle One) **M F**

Social Security Number Relationship to Client (circle one)
parent spouse guardian other:

COMMUNICATION CLEARANCE (Circle)

Telephone: Home Y N Cell 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 (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

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 Claim Payment

I hereby authorize my health care provider to release information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.

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 ____