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 | Email | Sex (Choose One) ☐ **M** ☐ **F**

Status (choose 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 (Choose one) ☐ **M** ☐ **F**

Email | Relationship to Client (choose 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.? (Choose 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 check 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 (choose 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 (choose 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 _____