COUNSELING ASSOCIATES CLIENT INFORMATION FORM

Purpose: We are usually quite successful in helping people cope with stress and difficulties, although no one can solve your problems for you. Your counselor will listen and be helpful to the fullest extent of his/her professional capabilities. It is by discussing your thoughts and feelings that we can work as a team to obtain the best results. All counseling sessions are completely confidential. No information will be released without your consent**. Please print legibly.**

TODAY'S DATE:_____

CLIENT NAME:_____ BIRTHDATE:_____ ADDRESS:_____ CITY:_____STATE:_____ ZIP:_____PHONE#_____ COUNTY OF RESIDENCE:_____ SEX: MALE FEMALE (circle one) SOCIAL SECURITY #_____	RESPONSIBLE PERSON: NAME:_____ RELATIONSHIP TO CLIENT:_____ ADDRESS:_____ CITY:_____STATE:_____ ZIP:_____ PHONE#_____ COUNTY OF RESIDENCE:_____ SEX: MALE FEMALE (circle one) SOCIAL SECURITY #_____

CELL PHONE:_____ EMAIL:_____

HOME PHONE:_____ WORK PHONE:_____

(IS IT OK TO LEAVE A MESSAGE AT HOME #) YES NO

CLIENT MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ WIDOWER ☐ MARRIED ☐ SEPARATED ☐ DOMESTIC PARTNER

EMPLOYED: ☐ FULL TIME ☐ PART TIME ☐ SHELTERED EMPLOYMENT ☐ RETIRED ☐ HOMEMAKER ☐ UNEMPLOYED ☐ STUDENT

EMPLOYER: _____

HOW DID YOU HEAR ABOUT OUR SERVICES? ☐ ONLINE ☐ FRIEND/FAMILY ☐ PHONEBOOK ☐ REFERRED ☐ NEWSPAPER ☐ OTHER_____

IN CASE OF EMERGENCY CONTACT: (Name)_____
PHONE:_____ RELATIONSHIP:_____
CLIENT'S CURRENT MEDICATIONS:_____
_____
ANY ALLERGIES?_____
PHYSICIAN:_____ PHONE #_____
PERMISSION TO CONTACT PHYSICIAN?_____

HAS THE CLIENT EVER HAD COUNSELING?_____ WHEN?_____
BY WHOM?_____ WAS IT HELPFUL?_____

Continued on other side…

All counseling appointments are scheduled in advance. We reserve a specific time period (usually 50 minutes) to each client. It is important that you realize that a block of time has been set aside for you. If an appointment is not cancelled (no show), you will be charged accordingly.

Financial Agreement

____**Self Pay**: I will be paying for the services I receive at this clinic. I will make a full payment of $_____each time I come unless other approved arrangements have been made.

NOTE: If you choose this option, this clinic will not bill any insurance company at a later date.

_____**Insurance payment:** I will give all insurance information required to the staff and request that they submit the charges to my insurance company for payment. I understand my insurance may not pay in full or may deny my services. I understand that I am financially responsible for **all** charges. This includes my deductible and/or copay. I authorize this clinic to furnish to my insurance company all information that may be required in order to process the claims for me and/or my dependents.

Please present your insurance card at time of initial appointment. If you do not have your insurance card please fill out the following **thoroughly:**

Name of Insurance:_____

Address of Insurance Company:_____

Policy/ID #:_____**Group#:**_____

Name of Policy Holder:_____

Employer:_____

Assignment of Benefits

I hereby instruct and direct my insurance company to pay for my services by check made out and mailed to :

Counseling Associates, LLC; 111Market Street Suite 4A; Winona, MN 55987

If my current policy prohibits direct payment to provider, I hereby also instruct and direct my insurance company to make the check out to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current policy as payment toward the total charges for services rendered. This is a direct assignment of my rights and benefits under this policy. I have agreed to pay any balance of said charges for professional services over and above this insurance payment. A copy of this assignment shall be considered as effective and valid as the original.

I have read and understand my Rights and Responsibilities as written in the "Client Information Booklet."
I have read and understand the above financial policy of Counseling Associates.

I GIVE MY CONSENT FOR TREATMENT.

Patient signature (Parent if Minor):_____ Date:_____

Therapist:_____ Witness: _____