The Center for Counseling & Wellness
Client Information Sheet

Client Name:_____ **Date:**_____
Last First MI

Address:_____
Street City State Zip

Social Sec. #: _____-_____-_____ **Marital Status:** M☐ S☐ D☐ W☐ Sep☐ O☐

Primary Phone: _____ (☐) Home (☐) Cell (☐) Work

Secondary Phone: _____ (☐) Home (☐) Cell (☐) Work

Gender: (☐) Male (☐) Female **Date of Birth:**_____-_____-_____ **Age:**_____

Parent/Guardian (if Minor/Disabled):_____
Last First MI

Address _____
(If different from above)

Relationship to client: _____

Primary Phone: _____ (☐) Home (☐) Cell

Emergency Contact Name: _____
Last First MI

Phone:_____ **Relationship to Client:**_____

Primary Care Physician _____
Name Phone

Employment Status: (☐) Employed (☐) Unemployed (☐) Disabled (☐) Retired

How did you learn about us? (☐) Family (☐) Friend (☐) Church (☐) School

(☐) Insurance (☐) Internet (☐) Doctor (☐) Sign/Brochure (☐) Other _____

Person Completing Form _____
Name (Relationship to Client)

The Center For Counseling & Wellness

CLIENT NAME: _____

CLIENT'S DATE OF BIRTH: _____

FINANCIAL COVENANT AGREEMENT

☐ **INSURANCE** *(Fill out this section if you are using insurance to pay for treatment)*

PRIMARY INSURANCE CARRIER:

Name of Insurance:	Policy #:
Policy Holder:	Relationship to insured:
Home Address:	City/State/Zip:
Insured's Date of Birth:	Phone #:

SECONDARY INSURANCE CARRIER:

Name of Insurance:	Policy #:
Policy Holder:	Relationship to insured:
Home Address:	City/State/Zip:
Insured's Date of Birth:	Phone #:

☐ **PRIVATE OR THIRD PARTY PAYMENT** *(Fill out this section if insurance is not applicable.*

Sliding Fee Scale: Agreed Amount _____ Staff Initials: _____	**Third Party Payor:** Name: _____ Address: _____ Contact Number: _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I understand I am personally responsible for payment of all insurance co-pays and deductibles regardless of any insurance payments made to The Center for Counseling & Wellness (The Center). I authorize The Center to release all information necessary to process any insurance claims or third-party payment. I **authorize payment of insurance benefits directly to The Center**. I understand the Late Cancellation fee of $25 is not covered by insurance and is accordingly my responsibility. I further understand that my account needs to remain current to continue in the counseling process.

_____ _____

Client Signature/Parent or Guardian Signature if Minor Date

_____ _____

Counselor Signature Date

The Center for Counseling & Wellness

Client Intake Signature Form and Virtual Care Emergency Contact Information

Client Name_____

My signature below confirms that I have received, reviewed, and/or completed a copy of:

- **The Center for Counseling & Wellness' Disclosure Statement with Informed Consent to Participate in Clinical Counseling, HIPAA Rules, and Virtual Care Disclosure**
- **Notice of Privacy Practices for The Center for Counseling & Wellness**
- **The Center For Counseling & Wellness Biopsychosocial History Intake Form**
- **My counselor's personal Professional Disclosure Statement**

and have had an opportunity to discuss any questions I have about this information. I acknowledge that a copy of these documents has been made available to me at no charge and that they are available on our website at thecenter4counselingcom.

_____

Client's Signature (Parent/Guardian if client is a minor) Date

_____

Witness Signature Date

In emergency situations for Virtual Care, contact:_____ at _____
Local Police Department Phone #

For disruption of service for Virtual Care, contact:_____ at_____
Land line or other cell phone Phone#

My Client Support Person for Virtual Care is:_____ at_____
Name Phone #

My email address is:_____

Updated 7/10/2020

THE CENTER

for Counseling & Wellness

www.thecenter4counseling.com

Credit Card Authorization Form

Credit Card Information Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Cardholder Billing Address & Zip Code:

_____

_____

I, _____ (client name), authorize *The Center for Counseling & Wellness*, to charge my credit card listed above for Virtual Care Services. I understand that my information will be saved to file for future transactions on my account.

I agree to pay $_____for each individual session.

Signature of Patient/Representative _____ Date _____

Patient Printed Name _____ Date of Birth _____

Relationship to Patient_____ Witness _____

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