The Center for Counseling & Wellness
Client Information Sheet

Client Legal Name: _____
First Middle Last

Client Preferred Name: _____
First Middle Last

Address: _____
Street City State Zip

Social Sec #: _____ **Marital Status: __M __S __ D __ W __ Sep __O**

Primary Phone: _____ **Type:**_____ **Secondary Phone:** _____ **Type:**_____

Gender Assigned at Birth: _____ **Identified Gender:** _____

Preferred Pronouns: _____ **DOB:** _____ **Age:** _____

Email Address: _____

Parent/Guardian (If Minor/Disabled):_____
First Middle Last

Relationship to Client: _____ **Phone #:** _____**: Type:**_____

Emergency Contact Name: _____
First Middle Last

Relationship to Client: _____ **Phone #:** _____**: Type:**_____

Local Police Department (City/County): _____ **Phone #:** _____

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: _____
Relationship to Client

THE CENTER

For Counseling and Wellness

www.thecenter4counseling.com

The Center for Counseling & Wellness

Client Intake Signature Form

Client Legal Name_____

Client Preferred 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 thecenter4counseling.com.

_____

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

Updated 08/20/2023

110 Ye Old Kings Highway, North Myrtle Beach | 4466 Holmestown Road, Myrtle Beach
3505 Main Street, Loris | 602 Main Street, Conway
Phone (843) 663-0770 | Fax (843) 663-0772 l Email: admin@thecenter4counseling.com

CLIENT LEGAL NAME AS SHOWN ON INSURANCE CARD: _____

CLIENT PREFERRED NAME: _____CLIENT'S DATE OF BIRTH: _____

FINANCIAL COVENANT AGREEMENT

The Center for Counseling & Wellness

_____ 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 client:
Home Address:	City, State, Zip:
Policy Holder's Date of Birth:	Phone #

_____ SECONDARY INSURANCE CARRIER:

Name of Insurance:	Policy #
Policy Holder:	Relationship to client:
Home Address:	City, State, Zip:
Policy Holder'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 $50** is not covered by insurance and is accordingly my responsibility (*does not apply to Medicaid clients*). **There will be a $25 fee for all returned checks. I understand if I am a self-pay client, I have the right to a good faith estimate of the cost of each visit and the agreed amount above is such an estimate.** I further understand my account needs to remain current to continue in the counseling process.

_____ _____

Client Signature/Parent or Guardian Signature if Minor Date

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Credit Card Authorization Form

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

Cardholder Name (as shown on card): _____

Card Number: _____ CVV: _____

Expiration Date (mm/yy): _____

Cardholder Billing Address & Zip Code:

_____

_____

I, _____ (client legal name), authorize *The Center for Counseling & Wellness*, to charge my credit card listed above for counseling 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 Client/Representative _____ Date _____

Client Printed Name _____ Date of Birth _____

Relationship to Client_____

*****ALL CREDIT CARDS WILL BE SUBJECT TO A 3.5% PROCESSING FEE *****

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