Therapist:_____ **Diagnosis:**_____

_____

Elmbrook Family Counseling Center
Confidential Client Information Sheet

Date:_____ Who referred you to us?_____Primary Care Physician:_____

Legal Name:_____Preferred Name (if different):_____
(Last) (First) (Middle Initial)

Address:_____City:_____State:_____ZIP:_____

Cell Phone :(_____)-_____-_____ Home Phone :(_____)-_____-_____ Email: _____

Date of Birth:_____ Age:_____ Social Security Number:_____

Marital Status:_____ Sex :_____Gender Identity (if applicable):_____

Employer Name/Position Title:_____

Employer Address:_____City:_____State:_____ZIP:_____

Work Phone :(_____)-_____-_____

Emergency Contact Name/Relation:_____Phone: (____)-_____-_____

Person Financially Responsible/Relation (if different from above):_____

Address:_____City:_____State:_____ZIP:_____

Phone:(____)-_____-_____

1st Insurance Carrier:_____Policyholder's Name:_____

1st Policyholders Date of Birth:_____ Social Security Number:_____

2nd Insurance Carrier:_____Policyholder's Name:_____

2nd Policyholders Date of Birth:_____ Social Security Number:_____

PATIENT ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I acknowledge that I have received a copy of the patient bill of rights and grievance procedure and the informed consent for treatment form. I hereby agree to treatment and understand that should I have questions I will contact my therapist or the clinic staff.

I hereby authorize any insurance carrier to make payment directly to Elmbrook Family Counseling Center (EFCC) of any benefits otherwise payable to me for services provided by any member of EFCC professional staff. I understand that I am financially responsible for all charges whether or not paid by the said insurance. I further authorize EFCC to release to my insurance company(s) any information from my record, which may be necessary to determine benefits payable under my policy. This information may include, but is not limited to: diagnosis, treatment procedures, and/or photocopies of all or part of my record.

Client or Guardian Signature:_____Date:_____

Witness Signature (if applicable):_____Date:_____