Therapist:___________________________

Diagnosis:___________________________

Elmbrook Family Counseling

CLIENT INFORMATION SHEET

CONFIDENTIAL

WHO REFERRED YOU TO US ?____

DATE: ____________ PRIMARY CARE PHYSICIAN NAME ______________________________

CLIENT NAME: ____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS: ____________________________________ CITY: ____________________

STATE: ________________ ZIP:_________ HOME PHONE: (____)-_____-________

MARITAL STATUS: _________ SEX: ______ SOC SEC#_______________BIRTHDATE:__________AGE:_____

EMPLOYER NAME/ADDRESS: ______________________________WORK PHONE:(____)-_____-________

EMERGENCY CONTACT NAME: ____________________ EMERGENCY PHONE # (____)-_____-________

PERSON FINANCIALLY RESPONSIBLE: __________________RELATIONSHIP TO CLIENT: __________

ADDRESS: ____________________________________ CITY: ____________________

STATE: ________________ ZIP:_________ HOME PHONE: (____)-_____-________

1ST INSURANCE CARRIER: ____________________POLICYHOLDER'S NAME: __________________

1ST POLICYHOLDER'S DATE OF BIRTH: ______________ SOCIAL SECURITY # __________________

2ND INSURANCE CARRIER: ____________________POLICYHOLDER'S NAME: __________________

2ND POLICYHOLDERS DATE OF BIRTH: ______________ SOCIAL SECURITY # __________________

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 (EFC) of any benefits otherwise payable to me for services provided by any member of EFC professional staff. I understand that I am financially responsible for all charges whether or not paid by the said insurance.

I further authorize EFC 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 procedure and/or photocopies of all or part of my record.

______________________________ Patient or Guardian Signature

______________________________ Witness Signature ____________________ Date