

CLIENT INFORMATION FORM

(Please Write Legibly)

Today's Date ____/____/____

Therapist: _____

CLIENT INFORMATION

Client's Last Name		First	Middle	Ethnicity	Marital Status (Circle One) Single / Married / Divorced / Remarried / Other	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address	City	State	ZIP Code	Social Security - -	Home Phone - OK Leave Message? Y N ()	
P.O. Box	City	State	ZIP Code	Cell Phone - OK Leave Message? Y N ()		
Occupation	Employer			Work Phone - OK Leave Message? Y N ()		

Referred by (Please check one box & fill in if needed)

- Pastor/Church: _____ Dr. _____ Insurance Plan Website
 Family Friend Close to Home/Work Psychology Today Other _____

Email Address:	Alternative Email Address:
PAYMENT - <input type="checkbox"/> Self Pay <input type="checkbox"/> Dunn Hope Fund Fee: _____	Would you like to be on our mailing list? <input type="checkbox"/> Yes <input type="checkbox"/> No
I would prefer to receive mailing list items: <input type="checkbox"/> By Regular Mail <input type="checkbox"/> By Email	

INSURANCE INFORMATION (NOTE - ISCC ACCEPTS CASH OR CHECK ONLY FOR PAYMENT)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ()
Email Address:			Cell Phone No. ()
Occupation	Employer	Employer Address	Work Phone No. ()
Are you covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this an EAP Visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer:	Total EAP Sessions approved? _____

Please Select Your Primary Insurance Provider

- Cigna Aetna Aetna EAP United Behavioral Health TriCare United Healthcare
 Value Options Medicare Compsych Other _____

What is the authorization number? _____

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
Client's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance (if any)		Insured's Name		Group #	Policy #
Client's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

CLIENT INFORMATION FORM

PLEASE READ THE FOLLOWING CAREFULLY – Initial Each Item and Sign Below

_____ I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. If my insurance policy or other third party coverage does not pay ISCC for services rendered, I am responsible for the full amount of ISCC's fees (unless otherwise prohibited by insurance company regulations communicated to ISCC as part of the authorization process. Interface-Samaritan Counseling Centers and our staff therapists will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

_____ I understand that missed appointments and cancellations (less than 24 hours in advance) are billed to clients and that my health insurance will not pay for missed appointments/late cancellations. I understand that I will be billed the full contracted fee with the insurance company (not my copay amount) for missed appointments/late cancellations.

_____ The subsidy for my fees from the Dunn Hope Fund is contingent on contributions. I understand If these contributions are not forthcoming, ISCC cannot provide the subsidy. I understand that I am responsible for payment prior to each session of the agreed fee.

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I have read and understand the above conditions.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

CLIENT INFORMATION FORM

What is your reason for seeking help now? _____

Are any of the following conditions a problem or struggle for you at this time? (Check the ones that apply):

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Self Esteem | <input type="checkbox"/> Loss of Meaning in Life | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Loss of Faith in God | <input type="checkbox"/> Depression | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Conflicts at Work | <input type="checkbox"/> Irrational Fears | <input type="checkbox"/> Chronic Fear | <input type="checkbox"/> Religious Doubts |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Guilt Feelings | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Suicidal Feelings | <input type="checkbox"/> Anger | <input type="checkbox"/> Loss of Hope | _____ |
| <input type="checkbox"/> Marriage Problems | <input type="checkbox"/> Rage | <input type="checkbox"/> Sexual Problems | _____ |
| <input type="checkbox"/> Relationship to Parents | <input type="checkbox"/> Relationship to Children | <input type="checkbox"/> Loss of Work/Job | |

MEDICAL/PSYCHOLOGICAL HISTORY:

Name and address of your physician: _____

When was your last medical examination? _____

Are you struggling with any physical illnesses or symptoms at this time? _____

List current medications: _____

Have you received psychotherapy or counseling in the past? Yes No When? _____

Name of treating therapist: _____

SPIRITUAL CONCERNS:

How important is spiritual commitment to you?

- Unimportant Below Average Average Above Average Very Important

Do you desire having your spiritual beliefs and values incorporated into the therapy process?

- No Yes Not Sure

Church/Congregation (name/location): _____

Worship Leader's Name: _____

Denomination: _____

ACKNOWLEDGEMENT: Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

CLIENT SIGNATURE

DATE