

## **Family Concern Counseling - Client Information**

Name _____			Sex <input type="checkbox"/> M <input type="checkbox"/> F
Last Name	First Name	Middle Initial	
Address _____		City _____	
State _____	Zip _____	Home Phone (____) _____	
E-mail address _____		Cell Phone (____) _____	
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Single	<input type="checkbox"/> Minor
<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	Soc Sec # _____	Birthdate _____
Client Employer/School _____		Employer/School Phone (____) _____	
Whom may we thank for referring you? _____			

Counselor _____	<b>- Primary Insurance -</b>	DSM IV _____
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Person Responsible for Account _____			
Last Name	First Name	Middle Initial	
Relation to Client _____	Birthdate _____	Soc. Sec. # _____	Phone (____) _____
Address (if different from Client's) _____			
City _____	State _____	Zip _____	
Person Responsible Employed by _____		Occupation _____	
Business Address _____		Business Phone (____) _____	
Insurance Company _____			
ID# _____	Group # _____	Subscriber # _____	

### **- Additional Insurance -**

Is client covered by additional insurance? <input type="checkbox"/> yes <input type="checkbox"/> no			
Subscriber Name _____		Relation to Client _____	
		Birthdate _____	
Address (if different from client's) _____		Phone (____) _____	
City _____	State _____	Zip _____	
Subscriber Employed by _____		Business Phone (____) _____	
Insurance Company _____			
Contract # _____	Group# _____	Subscriber # _____	

### **- Assignment and Release -**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
Name of Insurance Company(ies)and assign directly to **Family Concern Counseling, Inc.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named provider may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I, the undersigned, agree, and consent to participate in the mental health services offered by \_\_\_\_\_, a mental health provider, as defined in Indiana law. I understand that I am consenting and agreeing only to those mental health services that the above named provider is qualified to provide within: (a) the scope of the provider's license, certification, and training, or (b) the scope of license, certification, and training of those mental health providers directly supervising the services received by me, the client.

\_\_\_\_\_  
Signature of Client, Parent, Guardian or Personal Representative Date \_\_\_\_\_

\_\_\_\_\_  
Please print name of Client, Parent, Guardian or Personal Representative Relationship to Client \_\_\_\_\_