COUNSELING ASSOCIATES CLIENT INFORMATION FORM

Purpose: We are usually quite successful in helping people cope with stress and difficulties, although no one can solve your problems for you. Your counselor will listen and be helpful to the fullest extent of his/her professional capabilities. It is by discussing your thoughts and feelings that we can work as a team to obtain the best results. All counseling sessions are completely confidential. No information will be released without your consent. **Please print legibly**.

TODAY'S DATE:

CLIENT NAME:	RESPONSIBLE PERSON (if not the client):
BIRTHDATE:	NAME:
ADDRESS:	RELATIONSHIP TO CLIENT:
CITY:	ADDRESS:
STATE:	CITY: STATE:
ZIP:	ZIP: PHONE#
PHONE#	COUNTY OF RESIDENCE:
COUNTY OF RESIDENCE:	
SEX: ◯ MALE ◯ FEMALE ◯ OTHER	

CELL PHONE: EMAIL:

HOME PHONE: WORK PHONE:

IS IT OK TO LEAVE A MESSAGE AT HOME PHONE? ◯ YES ◯ NO

CLIENT MARITAL STATUS: ◯ SINGLE ◯ DIVORCED ◯ WIDOW(ER) ◯ MARRIED ◯ SEPARATED ◯ DOMESTIC PARTNER

EMPLOYED: ◯ FULL TIME ◯ PART TIME ◯ SHELTERED EMPLOYMENT ◯ RETIRED ◯ HOMEMAKER ◯ UNEMPLOYED ◯ DISABLED ◯ STUDENT

EMPLOYER:

IN CASE OF EMERGENCY CONTACT: NAME:
PHONE: RELATIONSHIP

CLIENT'S CURRENT MEDICATIONS:

ANY ALLERGIES?

PHYSICIAN: PHONE #
PERMISSION TO CONTACT PHYSICIAN? ◯ YES ◯ NO

HAS THE CLIENT EVER HAD COUNSELING? ◯ YES ◯ NO WHEN?
BY WHOM? WAS IT HELPFUL?

Financial Agreement

☐ **Self-Pay**: I will be paying for the services I receive at this clinic. I will make a full payment of $_____ each time I come unless other approved arrangements have been made.

NOTE: If you choose this option, this clinic will not bill any insurance company at a later date.

☐ **Insurance payment**: I will give all insurance information required to the staff and request that hey submit the charges to my insurance company for payment. I understand my insurance may not pay in full or may deny my services. I understand that I am financially responsible for all charges. This includes my deductible and/or co-pay. I authorize this clinic to furnish to my insurance company all information that may be required in order to process the claims for me and/or my dependents.

Please present your insurance card at the time of the initial appointment. If you **do not have your insurance card** please fill out the following **thoroughly**:

Name of Insurance: _____

Address of Insurance Company: _____

Policy/ID#: _____ **Group#:** _____

Name of Policy Holder: _____ **Employer:** _____

All counseling appointments are scheduled in advance. We reserve a specific time period to each client. It is important that you realize that a block of time has been set aside for you. We request notification 24 hours prior to appointment if at all possible.

Assignment of Benefits

I hereby instruct and direct my insurance company to pay for my services by electronic payment of check made out and mailed to: Counseling Associates, LLC, PO BOX 185, Winona, MN 55987
If my current policy prohibits direct payment to provider, I hereby also instruct and direct my insurance company to make the check out to me and mail it to the above address for the professional or medical expenses allowable for the professional or medical expenses allowable, and otherwise payable to me under my current policy as payment toward the total charges for services rendered. This is a direct assignment of my rights and benefits under this policy. I have agreed to pay any balance of said charges for professional services over and above this insurance payment. A copy of this assignment shall be considered as effective and valid as the original.

X **Client signature** (Parent if Minor): _____ **Date:** _____

Therapist: _____ Witness: _____

INFORMED CONSENT

By my signature, I am indicating I have read and understood the Informed Consent Notice and the notice of Privacy Practices. I am requesting professional services from Counseling Associates, LLC. I understand that I can discuss any questions or concerns I have regarding my treatment, or these policies with my counselor or their supervisor. I also understand I may withdraw this consent and terminate counseling at any time for any reason, but it must be in writing and signed by myself or my legal guardian.

X **Client signature** (Parent if Minor): _____ **Date:** _____

Therapist signature _____ Date: _____

Consent effective no longer than 15 months from date signed.