



CLIENT INFORMATION Date _____

Client Name	Sex M _____ F _____	Date of Birth	Employed Unemployed Retired Other: _____
Address	City	State	Zip Code
How do you want to be reminded of appointments? (Circle One) Phone Call Text			
Okay to leave message Yes No			
Home Phone:		Cell Phone:	
Email:		Social Security #:	
Marital Status: Single Married Partnered Separated Divorced Widowed (Circle One)			
How did you hear about The Counseling Group? Internet Friend Employer Dr Other			

RESPONSIBLE PARTY (Person who will pay the fees if different from Client)

Responsible Party's Name	Relationship to Client: Circle One Parent Spouse/Partner Other		
Address if different from Client	City	State	Zip Code
Phone Number	SS#	Email	

EAP (Employee Assistance Program)

Name of Company:	
Name of Employee	Relationship to Client: Self Parent Spouse/Partner Other

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name Date of Birth	Subscriber Name Date of Birth
Patient's Relationship to Insured: (Circle One) Spouse Partner Child Self	Patient's Relationship to Insured: (Circle One) Spouse Partner Child Self
Subscriber ID # Group ID #	Subscriber ID # Group ID #
Subscriber Social Security #	Subscriber Social Security #

THERAPIST _____

CLIENT INFORMATION FOR COUNSELOR **Date**_____

Client Name: _____

Age: _____

Primary Care Physician Name:					
Medications:					
Education Level:					
Employer Name: _____					
Occupation: _____					
Marital Status: (Circle One)	Single	Married	Partnered	Separated Divorced	Widowed
Who lives in the Household:					
Have you been seen by a Counselor before? Yes No					
If Client is a Minor, Who is Parent/Legal Guardian?					
Name: _____			Relationship: _____		



Acknowledgement and Acceptance

Client Name: _____

Please **INITIAL** each statement below and sign in the space provided to affirm your acceptance of the following items:

_____ I have read the attached **Agreement for Services** and I agree to its Terms

_____ I have read the **Failed Appointment Policy** and I agree to its Terms

_____ I have read the attached **Telehealth Consent Form** and I agree to its Terms

_____ I have been provided with **the Professional Disclosure Statement** of my counselor

_____ I acknowledge receipt of the **HIPAA Notice** form

_____ I acknowledge receipt of the **Surprise Billing Protection** Form

Signature of Client (Parent or Guardian if client is a minor)

Date

Printed Name

Signature of Client (Minors 13-17 years of age)

Date

Printed Name