ADULT

Discoveries Counseling

How did you hear about us?

☐ Online
☐ School _____ ☐ Physician_____
☐ Relative_____ ☐ Other_____

Client Information Sheet

Contact Information:

First Name:_____Last Name:_____Date of Birth:_____

Address:_____City:_____Zip Code:_____

Home Phone: _____Work Phone: _____Cell Phone: _____E-mail:_____

Social Security#: _____Employer/School_____

Primary Care Physician's Name: _____Office Phone:_____

Current Medications:_____

May your therapist send a letter to your Physician indicating that you have begun counseling? (check one) ☐ Yes ☐ No

Members of Household:

Name	Relationship	DOB

Payment Information:

How would you like to pay for services? (check one) ☐Private Pay ☐ Medical Insurance ☐EAP ☐ Car Insurance

Plan_____Plan #_____Suffix_____

Subscriber's Name_____Date of Birth_____

Subscriber's Address (if different)_____City_____Zip_____

Employer_____

Any Additional Information you would like to share:

For Office Use Only

E_____ A_____ S_____ F_____ D_____

DC 12/12

Fee for Service Agreement:

I agree to pay all out of pocket costs for counseling services. If using my health insurance to assist with reimbursement for services, I hereby authorize release of information to my insurance company(ies) listed above for the purpose of reimbursement. I hereby authorize payment of third party reimbursement to be made directly to my counselor. If payment is made directly to the subscriber by a third party, I shall be held responsible for the full charge for service. I further agree that if insurance coverage terminates or benefits do not cover services in full, I shall be responsible for payment.

- **I agree to pay fees at the time of service. I understand that I will be charged $5.00 if my payment is delayed.**
- **I also understand that I will be charged $50 if I do not cancel/reschedule appointments with at least 24 hours notice.**

I certify that the above information is correct, and if any information changes, I will inform Discoveries Counseling immediately.

Signature:	Relationship:
Witness' Signature:	Date

_____"Yes, it is ok to use my email to communicate about private or billing issues."

_____"I understand that clinical updates will be communicated with all insurance companies as per their policies."

_____"It is OK to leave voicemail about my appointment time on all voicemail to the numbers I gave you."

Signature:	Relationship:
Witness' Signature:	Date

Would you like to join our E-newsletter; to receive articles on families, relationships and how to resist problems? Yes ☐ No ☐
E-mail_____

HIPAA COMPLIANCE

By signing below, I certify that I have been offered information on Discoveries Counseling's Privacy Policy in accordance with HIPAA.

All involved in meetings, even briefly, are to sign below:

Signature:	Date:
Witness' Signature:	Date:

Signature:	Date:
Witness' Signature:	Date:

Signature:	Date:
Witness' Signature:	Date: