Client Information

Date_____

Client's First Name _____ Last Name _____ MI _____

Address _____ City _____ State_____ Zip _____

Telephone (Home) _____ (Work) _____

Birthdate _____/_____/_____ Age _____ Gender _____F _____M Race _____

Client's Social Security # _____

Name of Spouse/Guardian _____ Phone _____

Address _____ City _____ State _____ Zip _____

Person Responsible for Payment _____ Soc. Sec. # _____

Signature of Person Responsible for Payment X _____ (Must be signed for services to begin)

DEBIT/ CREDIT CARD INFORMATION:

(INFORMATION MUST BE COMPLETED FOR INITIAL APPOINTMENT, IF NOT APPOINTMENT WILL NOT MOVE FORWARD)

I GIVE IWIN COUNSELING AUTHORIZATION TO CHARGE MY CREDIT/ DEBIT CARD $25 FOR ANY APPOINTMENTS THAT ARE NOT CANCELLED WITHIN 24 HOURS. I GIVE IWIN COUNSELING AUTHORIZATION TO CHARGE MY CREDIT/ DEBIT CARD $50 FOR ANY APPOINTMENTS THAT ARE NO SHOWED WITHOUT CANCELATION. I GIVE IWIN COUNSELING AUTHORIZATION TO CHARGE MY CARD FOR THE FULL PRICE OF THERAPY MINUS THE COPAY IF MY INSURANCE COMPANY DENIES THE CLAIM FOR THE APPOINTMENT COMPLETED.

NAME: _____

SIGNATURE: _____

DEBIT/CREDIT CARD NUMBER: _____ EXPIRATION DATE: _____

CVV NUMBER: _____ CARD ZIP CODE: _____

EMERGENCY INFORMATION

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____ Work _____

Address _____ City _____ State _____ Zip _____

Name (2) _____ Relationship _____ Phone _____ Work _____

Address _____ City _____ State _____ Zip _____

Psychiatrist _____ Phone _____

Address _____ City _____ State _____ Zip _____

Current Medications _____

Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs _____

Spouse: Place _____ Phone _____ Hrs _____

INSURANCE INFORMATION

Primary Insurance _____

Phone_____

Contract/ID# _____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth_____

Client's relationship to Subscriber

___Self ___Spouse ___Child ___Other_____

Secondary Insurance _____

Phone_____

Contract/ID# _____

Group/Acct# _____

Subscriber _____

Subscriber Date of Birth_____

Client's relationship to Subscriber

___Self ___Spouse ___Child ____Other_____

REFERRAL SOURCE

How did you hear of our clinic (or from whom)? _____

Address _____ City _____ State _____ Zip _____

Phone _____ Relationship to referral source _____

Are you currently participating in Vocational Rehabilitation Services with the Department of Assistive and Rehabilitative Services (DARS) **YES NO**

Have you participated in Vocational Rehabilitation Services with the Department of Assistive and Rehabilitative Services (DARS) within the last 5 years? **YES NO**