Monica E. Jackson, MS, LPC, CRC

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. You are responsible for payment even when using Insurance, Medicaid, or and EAP Company)**

DEBIT/ CREDIT CARD INFORMATION:

(INFORMATION MUST BE COMPLETED FOR INITIAL APPOINTMENT, IF NOT APPOINTMENT WILL NOT MOVE FORWARD) YOU ARE RESPONSIBLE FOR MISSED APPOINTMENTS EVEN IF YOU HAVE AN EAP, INSURANCE, OR MEDICAID INSURANCE BENEFITS.

I GIVE IWIN COUNSELING, PLLC 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 APPOINTMENTS CANCELLED WITHIN 5 HOURS OF SCHEDULED APPOINTMENT. (EXAMPLE: IF MY APPOINTMENT IS AT 6PM AND I CANCELLED BETWEEN 1PM AND 6PM). I GIVE IWIN COUNSELING AUTHORIZATION TO CHARGE MY CREDIT/DEBIT CARD THE FULL PRICE OF MY SESSIONS, WHICH IS THE COST OF THE COPAY AND THE COST INSURANCE PAYS FOR NO CALL AND NO SHOW APPOINTMENTS. 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. I UNDERSTAND THAT DECLINING TO SIGN MEANS THAT I AM DECLINING PARTICIPATION IN THERAPY WITH IWIN COUNSELING, PLLC.

NAME: _____

SIGNATURE: _____

DEBIT/CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____ CVV NUMBER: _____ CARD ZIP CODE: _____

EMERGENCY INFORMATION

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name (2) _____ Relationship _____ Phone _____

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 _____

Spouse: Place _____ Phone _____

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 Texas Workforce Solutions (formerly DARS)? **YES NO**

Have you participated in Vocational Rehabilitation Services with the Texas Workforce Solutions (formerly DARS) within the last 5 years? **YES NO**