ASSOCIATED COUNSELORS OF WEST COUNTY, INC.

New Client Information: (Please Print)

Name: last	first	mi
Address: street	city/state	zip
Phone: home	work	cell
SS#	date of birth	marital Status
employer/school	occupation	referred by

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Guarantor: (if different from client, or if client is a minor) **or Insurance Policy Holder**:

Name	SS#	date of birth
Address: (if different) street	city/state	zip
Phone: home	work	employer
relationship to client	Ins. Authorization #	co-pay amount

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Insurance: Please have your therapist make a copy of your insurance card

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Please Read and Sign Below

- I understand that appointments must be cancelled 24 hours in advance to avoid being charged the full fee - emergency exceptions are up to the individual therapist.
- If above named client is a minor, this is authorization for treatment.
- I authorize release of my medical and financial records to my insurance company, and authorize Associated Counselors of West County, Inc., to receive payment from my insurance company.
- I understand that I am financially responsible for any services not covered by insurance, and that such payments are due at the time of service.

I have read and agree to the above:

Signature of client/guarantor	date	relationship to client

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For Credit Card Payment:

Credit card #	expiration date	signature of card member
Office Use: Therapist:	DX:	rate: