Please fill out this form carefully and completely

Client Information

Date of Birth 1. _____ Age ___ Sex: M☐ F☐ Gender: M☐ F☐ Non-Binary☐ Other☐

Date of Birth 2. _____ Age ___ Sex: M☐ F☐ Gender: M☐ F☐ Non-Binary☐ Other☐

Preferred Pronouns: _____

Name(s) 1. _____ _____ _____

Name(s) 2. _____ _____ _____

First Initial Last

Contact Details

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: 1. _____ Cell Phone._____

Fax: _____ E-mail: _____

Employer Information

Employer: _____ _____

Company Occupation/Title

_____

Address

_____ _____ _____

City State Zip

Background & Health

Marital Status: ◯ Single ◯ Engaged ◯ Married ◯ Separated ◯ Divorced ◯ Widow(er)

Denomination or Religious preference: _____

Personal Physician or Group Practice: _____

Current Medications: _____ Any allergies: _____

In an emergency, please notify: _____

Phone: _____

Race: _____

Education-Highest Grade Completed: 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯10◯11◯12◯13◯14◯

Whom can we thank for your referral? (choose one)

Previous counselor or therapist: _____ When: _____ Number of Sessions: _____

◯Telephone Book ◯Yellow Pages ◯Newspaper ◯Minister ◯Friend ◯Co-Worker

◯Physician ◯Attorney ◯Client ◯Newsletter ◯Radio ◯TV ◯Brochure ◯Website

Counselor: _____ Appointment Day & Time: _____

I plan to use my insurance benefits _____
I plan to pay out-of-pocket _____

Statement of Understanding

I authorize the release of any medical information necessary to process insurance claims filed on my behalf. I hereby assign payment of insurance benefits to CCC. I acknowledge that I am financially responsible for the payment for services whether or not my health insurance covers services.
I have read and understand the center's policy on charges, insurance billing, 24-hour cancellations and missed appointments. I agree and accept financial responsibility for services rendered.
I have read my counselor's professional disclosure statement and asked questions, if needed.
I have been informed about how my privacy and confidentiality will be maintained by the Center (HIPPA statement). A copy of such is available if desired. Please ask your therapist.

Signature:_____ Date:_____