



Adjusted Fee \$ _____
(For Office Use Only)

CLIENT INFORMATION FORM

All information is kept confidential.

DEMOGRAPHIC INFORMATION

(Complete the following information for yourself. If the patient is your child, enter his/her name in the "Other Family Members" section.)

Name (Mr) (Mrs) (Ms) _____ Date _____
Circle one Please Print

Address _____

City, state, and zip code _____

Home phone _____ OK to call? () Yes () No Mobile _____ OK to call? () Yes () No

Work phone _____ OK to call? () Yes () No

Marital Status: Single _____ Married _____ How long? _____ Separated _____
Divorced _____ Widowed _____ Cohabiting _____

Your date of birth _____ Spouse name _____ Spouse date of birth _____

Other Family Members *(If the patient is your child, list his/her name here with your other family members.)*

Name	Relationship	Date of Birth	Age
1.			
2.			
3.			
4.			
5.			

Employer _____ Position _____

Employer (of spouse, if applicable) _____ Position _____

Religious preference (optional) _____ Church membership at _____

Person to contact in case of emergency: Name _____

Address _____ Phone _____

Name of person who will receive counseling or psychological services: _____

Social Security number of person receiving counseling _____

Problem category (check as many as apply):

- () Individual (adult) () Family
 () Individual (child) () Work related
 () Marital () Alcohol / drug related

Briefly describe the nature of your problem: _____

Have you (the person who will receive counseling) ever received mental health treatment? Yes () No ()

From whom? _____ When? _____

Medication prescribed (if any): _____

What prescribed medication are you (the person who will receive counseling) now taking? _____

Primary care physician _____ Other physician(s) _____

FINANCIAL INFORMATION (Please complete this section even if insurance will be used.)

Standard fee is \$120.00/initial evaluation, \$100.00/session. Your fee may be adjusted based on a sliding scale determined by gross (not take home) income. Payment is due at the time of the visit.

1. Your annual gross income: \$ _____

2. Spouse's annual gross income \$ _____

3. Annual Income from other sources (i.e. investments, stocks, bonds, savings, etc.) \$ _____

Total \$ _____

Payment will be made by _____ Cash _____ Check _____ Master Card/ Visa

There will be a \$20.00 charge for returned checks.

INSURANCE INFORMATION (All information below must be completed.)

1. Primary insurance company _____

Name of insured _____

Insured's address (if different from page 1) _____

Insured's social security # _____ Insured's date of birth _____

Insurance plan name _____ Insured's employer _____

Annual deductible amount _____ How much of deductible has been met this year? _____

Is the patient covered by another insurance policy? Yes () No () If yes, continue with question 2.

2. Second insurance company _____ Policy or group number _____

Name of Insured _____ Insurance plan name _____

Insured's address (if different from page 1) _____

Insured's birth date _____ Insured's social security # _____ Employer _____

Annual deductible amount \$ _____ How much of deductible has been met this year? _____

Insured or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process insurance claims on the patient's behalf. I authorize payment of medical benefits to AGAPE for services rendered.

Signed _____ Date _____