



AGAPE

Love Works

Fee amount \$ _____
(For Office Use Only)

CLIENT INFORMATION FORM

DEMOGRAPHIC INFORMATION –

This form should be completed by the adult who will be responsible for the primary person receiving services. His/her name should be entered in the space immediately below. If the primary person who will be the focus of services (i.e., the client) is a child/adolescent under 18 years of age, enter his/her name in the “Other Family Members” section below. All information will be handled confidentially.

Responsible adult's 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 client/patient is a child under 18 years of age, list his/her name below along with 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 (optional) _____

Person to contact in case of emergency: Name _____

Address _____ Phone _____

Name of primary person who will receive services (client/patient): _____

Social Security number of person named on line above (client/patient): _____ -- _____ -- _____

Briefly describe the primary problem for which services are being sought: _____

Has the person who will receive services (client/patient) ever received mental health treatment? Yes () No ()

From whom? _____ When? _____

Medication prescribed (if any): _____

What medication is currently being prescribed for the client/patient? _____

Primary care physician _____ Other physician(s) _____

FINANCIAL INFORMATION –

Standard fee is \$150.00/initial evaluation, \$120.00/regular 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. Important note! On occasion, insurance will not cover services even if an "authorization" from the insurance company has been obtained before hand. In such cases your fee would be based upon the information you supply in the section above (i.e., either sliding scale or standard fee).

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 SS# _____ -- _____ -- _____ 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 _____

