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Couple Information

Date:_____

1) Client:_____

2) Client:_____

☐Single ☐married ☐co-habit ☐ divorced ☐separated ☐widowed

1) Home address:_____

City_____zip_____

Date of Birth_____Age_____

Tel: Home:_____work_____

Cell_____Email_____

Preferred contact: ☐home ☐work ☐cell ☐email (check as many as you wish)

Employer_____Occupation_____how long____

2) Home address:_____

City_____zip_____

Date of Birth_____Age_____

Tel: Home:_____work_____

Cell_____Email_____

Preferred contact: ☐home ☐work ☐cell ☐email (check as many as you wish)

Employer_____Occupation_____how long____

Person to contact in emergency_____
name

_____
Address phone

Referred by:_____

Insurance Information (Subscriber Information)

Subscriber: _____

Relationship to Subscriber_____

Employed By_____

Birth Date:_____Address _____

Insurance Co:_____Policy/Group#_____

Insured ID#:_____Insurance Phone#_____

Insurance Claims Address:_____

Please attach a copy of the front and back of your insurance card.

In signing this agreement my signature acknowledges that I fully agree to and accept the following conditions:

- I authorize the release of medical or treatment information necessary to process my insurance claim including the release of a mental health or chemical dependency diagnosis.

- I accept full responsibility for payment should my insurance carrier not reimburse for services rendered. I understand and accept all financial responsibility for treatment.

1) Client Signature_____Date_____

2) Client Signature_____Date_____