

Beacon Center For Counseling

CLIENT INFORMATION FORM

***** Please Print *****

First Appointment: _____

Today's Date: _____

CLIENT INFORMATION:

Last Name: _____

First Name: _____

Middle Initial: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: () _____

Birth Date: _____

Cell Phone: () _____

Sex: Male _____ Female _____

Work Phone: () _____

Social Security #: _____

Ok to leave message at: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Employer: _____

Student: _____

In the event of an emergency Beacon may contact: _____

Relationship: _____ at phone number () _____

RESPONSIBLE PARTY PERSONAL INFORMATION (Guarantor):

(Do not complete this section if the Responsible Party information is the same as the client information)

Last Name: _____

First Name: _____

Middle Initial: _____

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

Home Phone: () _____

Birth Date: _____

Cell Phone: () _____

Sex: Male _____ Female _____

Work Phone: () _____

Social Security #: _____

Ok to leave message at: _____

PRIMARY INSURANCE INFORMATION:

(You must complete this section and present a copy of your insurance card for insurance to be billed)

Insurance Company: _____

Phone Number: () _____

INSURED PERSONAL INFORMATION (Subscriber):

Relationship to Client: _____

Employer: _____

I.D. #: _____

Group #: _____

Last Name: _____

First Name: _____

Middle Initial: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: () _____

Birth Date: _____

Cell Phone: () _____

Sex: Male _____ Female _____

Work Phone: () _____

Social Security #: _____

I authorize the release of any information necessary to process claims with my insurance company and I authorize my insurance company to make payments for my treatment directly to my Counselor. I understand that I am responsible for paying my deductible or co-pay (where applicable).

Signature _____ Date _____

I authorize my counselor to release information to Practice Management Solutions for the purposes of billing.

Signature _____ Date _____

PLEASE NOTE: We **do not** bill secondary insurance. If you choose to submit on your own, you must use the Explanation of Benefits statement sent by the primary insurance company to your address.

Counselor/Coach/CT: _____

Diagnosis 1: _____

Diagnosis 2: _____