BEACON CENTER FOR COUNSELING

Client Information Form

Please Print Clearly

First Appointment: _____ Today's Date: _____

CLIENT Information:

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( ) _____ Ok to text Re scheduling at: ( ) _____

Work Phone: ( ) _____ E-Mail Address: _____

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: _____ Sex: Male _____ Female _____

City:_____ State: _____ Zip Code: _____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( ) _____ Ok to text Re scheduling at: ( ) _____

Work Phone: ( ) _____ E-Mail Address: _____

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: _____ Social Security # _____

First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( ) _____ Ok to text Re scheduling at: ( ) _____

Work Phone: ( ) _____ E-Mail Address: _____

Ok to leave message at: _____

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 Counslor. 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 Electronic Medical Claims Consultants, LLC , 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.

For Office Use

Counselor/Coach/CT: _____

Diagnosis 1: _____ Diagnosis 2: _____