**Client Information Sheet**

Complete Circle Counseling and Coaching, P.A

***Please fill in information regarding patient to be seen***

|  |  |
| --- | --- |
| First Name: |  |
| Last Name: |  |
| Middle Name: |  |
| Street Address: |  |
| City, State and Zip code |  |
| Telephone Number: |  |
| SSN# |  |
| Date of Birth: |  |
| Current Age: |  |
| Sex: M/F/T/O |  |
| Work phone number: |  |

|  |  |
| --- | --- |
| Email Address: |  |
| Phone number you prefer to be reminded of appointments: |  |
| Education level OR current grade and name of school:  |  |
| Marital/Relationship Status: |  |

|  |  |
| --- | --- |
| Names and ages of ALL others living in the home: |  |
| Spouse’s name and phone number: |   |
| Who referred to us: |  |
| Who shall we contact in case of emergency (name and phone number): |  |

Responsible Party, if different from patient (this is the person signing the fee agreement and consent for treatment)

|  |  |
| --- | --- |
| First and Last Name: |  |
| Address: |  |
| Phone Number:  |  |
| SSN# |  |
| Date of Birth: |  |
| Current Age: |  |
| Sex (M,F,T,O) |  |
| Relationship to the patient: |  |

**Custody Information (Please select one) by indicating with a check mark**

|  |  |
| --- | --- |
|  | Child lives together with both parents and the court has not been involved in custody rulings |
|  | Child’s parents have joint legal custody. The other Parent’s name and address are: |
|  | Responsible party has sole custody of the child and the child lives with the responsible party. |
|  | Legal guardian is: Child resides with: |

**Primary Insurance**

|  |  |
| --- | --- |
| Insurance: |  |
| ID# |  |
| Group# |  |
| Policy holders name: |  |
| Policy holders Date of Birth: |  |
| Policy holders address and phone number: |  |
| Policy holders SSN# |  |
| Policy holders Employer and employer address: |  |

**FILL OUT IF THERE IS Secondary Insurance:**

Name/Address of Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Address if different from client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Phone number if different from client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All Clients using health insurance please sign below; parent must sign if client is under 18:**

***I hereby grant authorization to Rebeca Sandoval, LSCSW, to release any Protected Health Information (except Psychotherapy Notes) to my insurance company that is necessary for billing, to receive authorization for services, or to process my claim for payment of services. I authorize my insurance company to send payment directly to Rebeca Sandoval for all services provided. I agree that a photocopy of this authorization shall be as valid as the original.***

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Signature (Client, or parent or guardian if client is under 18 year old) Date