



Client Information Sheet

(Please Print)

First Name _____		MI _____	Last Name _____		SS# _____
Age _____	Date Of Birth _____		Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Legal Guardian: _____ <small>(If client is a minor)</small>	Biological Parent Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married* <input type="checkbox"/> Divorced* <input type="checkbox"/> Separated Divorcing*		*If not married or divorcing, please give second parent information below.		
Address _____		City _____		State _____	Zip _____
Home Phone _____		<input type="checkbox"/> Please do not leave a message.	Cell Phone _____		<input type="checkbox"/> Please do not leave a message.
Email _____		<input type="checkbox"/> Please do not send a message.			
Employer _____		Work Phone _____		<input type="checkbox"/> Please do not leave a message.	
Emergency Contact _____			Phone _____	Relationship _____	
*Non-Custodial/Shared Parent Name: _____ <small>(if child does not live with both parents)</small>			*Phone _____	<input type="checkbox"/> *Check if unknown	
*Address _____			*City, State _____	*Zip _____	

Billing Information

Insurance/EAP Carrier <small>(For mental health benefits)</small>	Member ID	Employer
Primary Policy Holder: <small>(If other than client)</small>	DOB	SS#
<input type="checkbox"/> I have contacted my insurance company and understand my mental health benefits <small>(Please note we are not responsible for this information)</small>		
My Counselor Is: <input type="checkbox"/> In Network <input type="checkbox"/> Out of Network With My Insurance Carrier		
Please fill in all sections. Authorization Number _____ Number of Sessions Authorized _____		Check box if using EAP sessions. <input type="checkbox"/> Dates: _____ to _____ EAP Name _____
Where did you hear about us? _____		<input type="checkbox"/> Please check if we may contact your referral source
<input type="checkbox"/> Please check here if you would like billing or other correspondence sent to a different address. <small>(Please ask for alternate mailing address form)</small>		

I agree that the insurance information I have provided is true and correct to the best of my knowledge. I understand it is my responsibility to obtain the initial authorization from my insurance company. If I fail to do so, I understand that I will owe full fee for services. I also understand that it is my responsibility to notify Arbor Counseling, LLC immediately of any changes in policy or benefit status. My signature indicates understanding and acceptance of the office policies presented and my responsibility for the payment of any incurred fees.

Signed _____ Date _____ © Arbor Counseling, LLC 2017