CLIENT INFORMATION

NAME_____
ADDRESS_____
STREET CITY STATE ZIP
SPOUSE'S NAME_____
HOME PHONE_____WORK PHONE_____
CELL PHONE_____PAGER_____
BIRTH DATE_____SOCIAL SECURITY #_____
EMERGENCY CONTACT_____PHONE_____

INSURANCE INFORMATION (IF APPLICABLE)

NAME OF
INSURED_____DOB_____SS#_____
RELATIONSHIP TO CLIENT_____
ADDRESS (IF DIFFERENT)_____
STREET CITY STATE ZIP
INSURANCE COMPANY_____
PHONE# (MAY BE MORE THAN ONE)_____
ADDRESS_____
POLICY #_____GROUP#_____

MEDICAID/MEDICARE(IF APPLICABLE)

A copy of your Medicare and/or Medicaid card will be needed at the time of your first session.
Medicare ID#_____
Medicaid ID#_____

FINANCIAL RESPONSIBILITY

I accept full responsibility for all financial obligations connected with counseling services rendered regardless of any commitment by any insurance program. I authorize the release of any information necessary to process insurance claims and the payment of any benefits of my insurance company to Debbie Kelly, LPC.

MasterCard, VISA and ATM cards are accepted.

Client Signature Date