CLIENT INFORMATON

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
EMPLOYER_____
INSURANCE COMPANY_____
PHONE #(MAY BE MORE THAN ONE)_____
ADDRESS_____
POLICY #_____GROUP #_____

MEDICAID/MEDICARE(IF APPLICABLE)

A copy of your Medicare and/or your 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 Gary T. Ongley, LMSW-ACP, LPC.

Master Charge, Visa, and Discover cards are accepted.

_____ _____
SIGNATURE DATE