Client Information Sheet

Name of Client: ____________________________________ M___ F___ Date: ___________________

Date of Birth: __________________ Age: _______ Grade in school: __________________________

Parent(s) Name(s) ____

Address: ____

City_________________________________ State ___________________ Zip code _______________

Home phone number: __________________Cell phone number: _______________________________

Mom's work number: _____________________ Dad's work number___________________________

Email address(es): ____

Insurance Coverage

Company: ____ PPO/HMO (circle)

ID# ____________________________ Group #____

Subscriber is: □ Self □ Mother____________________□ Father ______________________________

Subscriber's Social Security #:___________________ Subscriber's DOB _______________________

It is the client's or parent/guardian of a minor client's responsibility to determine the following:

Deductible? ___ yes ____ no If yes, how much? _______________Has it been met? _____________

Copayment: $_____________ # of sessions per year allowed _________________________________

Mental Health Benefits per year under this plan ____

Are individual mental health services covered? _____ yes _____ no

Are family mental health services covered? _____ yes _____ no

Any exceptions? ____

Insurance phone # (behavioral health) ____

Claims Address ____

Preauthorization required? ___ yes ____ no # of visits authorized _______________________

Authorization # ____