Spirit of Peace Clinical Counseling

CLIENT INFORMATION FORM

(please complete all the information requested on this form)

********** Please Print **********

First Appointment: _____ Today's Date: _____

CLIENT INFORMATION:

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ 9 Digit-Zip Code: _____-_____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____ Social Security #: _____

Ok to leave message at: _____ Email: _____

Ok to email appointment reminders? Yes:_____ No:_____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Employer: _____ Student/School/Grade: _____

In the event of an emergency SOPCC may contact: _____

Relationship: _____ at phone number ( )_____

RESPONSIBLE PARTY PERSONAL INFORMATION (Guarantor):

(Do not complete this section if the Responsible Party information is the same as the client information)

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____ City:_____ State: _____ Zip Code: _____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____ Social Security #: _____

Ok to leave message at: _____

PRIMARY INSURANCE INFORMATION: (This section is necessary for Spirit of Peace Clinical Counseling to receive payment from your Insurance/EAP for the counseling provided. *You must complete this section and present a copy of your insurance card for insurance to be billed*)

Insurance/EAP Company: _____

I am electing to self pay or insurance is not applicable: Initial_____ Date_____

INSURED PERSONAL INFORMATION (Subscriber):

Relationship to Client: _____ Employer: _____

I.D. #: _____ Group #: _____

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: ____ 9 Digit-Zip Code: _____-_____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____ Social Security #: _____

I authorize the release of any information necessary to process claims with my insurance company and/or EAP and I authorize my insurance company to make payments for my treatment directly to SOPCC. I understand that I am responsible for paying my deductible or co-pay (where applicable).

Signature _____ **Date** _____

I authorize SOPCC to release information to Practice Management Solutions for the purposes of billing and I understand I am responsible to pay the fees incurred for this service.

Signature _____ **Date** _____

PLEASE NOTE: We **do not** bill secondary insurance. If you choose to submit on your own, you must use the Explanation of Benefits statement sent by the primary insurance company to your address.

This section must be completed by the Clinician BEFORE paperwork is processed

Clinician: _____ Location: _____

Estimated amount due at time of service (co-pay and/or deductible): $ _____

Reduced fee (non-insurance only): $ _____ Write off: $ _____

Diagnosis 1: _____Diagnosis 2: _____

Miscellaneous/EAP Information: _____
Referring Physician (if applicable)_____