Please Print

CONFIDENTIAL CLIENT INFORMATION

Date: _______________

Name: ____
First Middle Last

Address: ____
Number Street City State Zip

Mailing Address (if different): ____
Number Street City State Zip

Home Phone: ( )__________________ Mobile Phone: ( )________________ Other Phone: ( )________________

Ok to Call? ❑ Yes ❑No ❑ Yes ❑No ❑ Yes ❑No

Ok to Leave a Message? ❑ Yes ❑No ❑ Yes ❑No ❑ Yes ❑No

Social Security #: ______-______-______ Date of Birth: __________________ Email: ________________________

Sex: ________ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Other ________________________

Employer: ____ ❑ Full Time ❑Part Time

Student: ❑ Full Time ❑Part Time Referred by: ________________________________

INSURANCE INFORMATION

Primary Insurance Carrier: ________________________________ Ins. Phone #:______________________

Address: ____

Policy Holder (Name): ________________________________Date of Birth: ________________

Address: ____ Sex: ❑ Male ❑Female

Home Phone: ( ) ____________ Work Phone: ( ) ____________ Mobile: ( ) ________________

Employer: ________________________________ Email: ____________________

Social Security #: ______-______-______ Policy/I.D#: ________________________________

Group #: ________________________________

Relationship of patient to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other ________________________

Secondary Insurance Carrier: ________________________________ Ins. Phone #:____________________

Address: ____

Policy Holder (Name): ________________________________Date of Birth: ________________

Address: ____ Sex: ❑ Male ❑Female

Home Phone: ( ) ____________ Work Phone: ( ) ____________ Mobile: ( ) ________________

Employer: ________________________________ Email: ____________________

Social Security #: ______-______-______ Policy/I.D#: ________________________________

Group #: ________________________________

Relationship of patient to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other ________________________

RESPONSIBLE PARTY INFORMATION

Person Responsible for Payment (if other than patient)

Name: ____ Check if: ❑ Custodial Parent ❑ Legal Guardian

Home Phone: (   ) ____________ Work Phone: (   ) _____________ Mobile: (   ) __________________

Relationship to Patient: _____________________________________ Email: ______________________

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process all claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: ____ DATE: _____________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to metta counseling services, for all services provided.