Fee amount $ ____________________
(For Office Use Only)

CLIENT INFORMATION FORM

DEMOGRAPHIC INFORMATION –

This form should be completed by the adult who will be responsible for the primary person receiving services. His/her name should be entered in the space immediately below. If the primary person who will be the focus of services (i.e., the client) is a child/adolescent under 18 years of age, enter his/her name in the “Other Family Members” section below. All information will be handled confidentially.

Responsible adult’s name (Mr) (Mrs) (Ms) ____________________________________ Date ___________________
Circle one *Please Print*

Address ____

City, state, and zip code ____

Home phone ________________ *OK to call? ( )Yes ( )No* Mobile _______________ *OK to call? ( )Yes ( )No*

Work phone ____ *OK to call? ( )Yes ( )No*

Marital Status: Single ________ Married ________ How long? _________ Separated __

Divorced _____ Widowed ________ Cohabiting __________

Your date of birth _______________ Spouse name ___________________ Spouse date of birth_________________

Other Family Members *(If the client/patient is a child under 18 years of age, list his/her name below along with other family members)*

Name	Relationship	Date of Birth	Age
1.			
2.			
3.			
4.			
5.			

Employer ____ Position ________________________

Employer (of spouse, if applicable)____________________________________ Position ________________________

Religious preference (optional) ___________ Church membership at (optional) _________________________________

Person to contact in case of emergency: Name ____

Address____ Phone _________________

Name of primary person who will receive services (client/patient): ____

Social Security number of person named on line above (client/patient): ________--______--_________

Briefly describe the primary problem for which services are being sought: _______________________________________

____

____

Has the person who will receive services (client/patient) ever received mental health treatment? Yes ( ) No ( )

From whom? ______________________________ When? ______________________________

Medication prescribed (if any): ____

What medication is currently being prescribed for the client/patient? ______________________

____

Primary care physician ______________________ Other physician(s) ____________________

FINANCIAL INFORMATION –

Standard fee is $150.00/initial evaluation, $120.00/regular session. Your fee may be adjusted based on a sliding scale determined by gross (not take home) income. Payment is due at the time of the visit.

1. Your annual gross income: ....$ ______________________
2. Spouse's annual gross income ....$ ______________________
3. Annual Income from other sources (i.e. investments, stocks, bonds, savings, etc.) ....$ ______________________

Total $ ______________________

Payment will be made by _________Cash ___________Check ______________Master Card/ Visa

There will be a $20.00 charge for returned checks.

INSURANCE INFORMATION -- ***All information below must be completed.*** **Important note! On occasion, insurance will not cover services even if an “authorization” from the insurance company has been obtained before hand. In such cases your fee would be based upon the information you supply in the section above (i.e., either sliding scale or standard fee).**

1. **Primary insurance company** ____

Name of insured ____

Insured’s address (if different from page 1) ______________________________________

Insured's social security **#** ______ -- ____ -- _______ Insured’s date of birth: ____ / ____ / ____

Insurance plan name ____________________________ Insured's employer____________________

Annual deductible amount ____________________ How much of deductible has been met this year?__________

Is the patient covered by another insurance policy? Yes ( ) No ( ) If yes, continue with question 2.

2. **Second insurance company** ________________________________ Policy or group number ___________

Name of Insured ___________________________ Insurance plan name ______________________

Insured’s address (if different from page 1) ______________________________________

Insured's birth date: ____ / ____ / ____ Insured's SS# ____ -- ____ -- ____ Employer:______________________

Annual deductible amount $ __________________ How much of deductible has been met this year?__________

Insured or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process insurance claims on the patient's behalf. I authorize payment of medical benefits to AGAPE for services rendered.

Signed ____ Date ______________________

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