Community Counseling Center
Client Information

1. Name: _____
(Last) (First) (Middle Initial) (Nickname)

2. Address: _____
(Street) (City) (State) (Zip)

3. Home Phone: (____) _____ 4. Work Phone: (____) _____ Extension # _____

5. Email Address (optional) _____

6. Social Security # _____ 7. Birth date: _____ Age: _____ 8. Sex: M F 9. Marital Status: S M D W

9. Employer: _____ Phone: (____) _____ Occupation: _____

10. Student/School: _____ Full Time _____ Part Time _____

11. If dependent child, are custodial parents: _____Married _____Separated _____Divorced _____Other _____

12. In Case of Emergency Notify: Name _____ Relation _____ Phone (____) _____

13. Primary Care Physician: _____ City: _____ Phone (____) _____

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR) INFORMATION
If same as patient, please complete only #1 & #6 of this section

1. Guarantor Name: _____ Birth date: _____
(Last) (First) (MI)

2. Guarantor Address: _____
(Street) (City) (State) (Zip)

3. Social Security #: _____ 3. Guarantor Relationship to Client: _____ 4. Home Phone: (____) _____

6. Guarantor Employer: _____ Occupation: _____ 5. Work Phone: (____) _____

8. Special Arrangements: _____

DO YOU HAVE INSURANCE? _____YES _____NO (IF YES, PLEASE COMPLETE BELOW)

1. **Primary** Insurance Company Name: _____ Phone: (____) _____

Insurance Company Address: _____

2. Subscriber's Name: _____ 3. Relation to Client: Self Spouse Parent Other _____

Employer: _____ Wk Phone: (____) _____ Occupation: _____

4. Birth date: _____ 5. Group ID #: _____ 6. Social Security #: _____

7. Insurance Identification Number: _____

If Community Counseling Center is contracted to bill your insurance company, Please sign the following section:

GENERAL INFORMATION: We will gladly bill your primary insurance company if we are contracted with them. If you have a secondary insurance you will be responsible for submitting charges to them for reimbursement. It is your responsibility to acquire initial authorization if required and number of session allowed annually by your insurance company. We will assist in providing any information possible for you regarding correspondence with your insurance company.

ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to Community Counseling Center the amount due for services rendered to my dependent or me.

RELEASE OF INFORMATION: I authorize the release, to my insurance company, of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to me or my dependent. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

SIGNED: _____ _____ DATE: _____
INSURED PARENT GUARDIAN

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Community Counseling Center. If the provider is contracted with the insurance company, I will be responsible only for the co-pay, deductible, and non-covered services as determined by the insurance plan.

_____ _____
Guarantor Signature (patient signature, if patient is guarantor) Date