Rachel Whetten Counseling and Psychotherapy

Client Information

Client Name : ____
First Middle or Initial Last

Preferred Name: ____

Home Address: ____
Street

____
City State Zip

Birth Date: ____________ Current age: _____ SS#: ____________________________

Phone: (C)___________________________ (W) ___________________________

Email Address: ____

Preferred method of communication? ____

Emergency Contact: ____
Name Best Number

Relationship to you? ____

Permanent address (if different from above): ____
Street

(cont.) ____
City State Zip

Referred by: ____

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Insurance Information

Client Gender: __________

Insurance Carrier: ________________________________ Phone: __________________________

Policy Holder: ______________________________________ Relationship: ___________________

Name of policy holder (if not self): ____
First Last

Gender: ______________ Date of Birth: ________________ SS# ___________________________

Employer: ____

Policy #: _______________________________ Group #: _________________________________

Person responsible for payment

Name: ____ SS#: ____________________________

Address: ____
Street City State, Zip

Phone: (C): ____________________________ (W) _______________________________________

You will be responsible for payment if insurance refuses to pay for services rendered

If using insurance, sign below client's or authorized persons signature:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below. I also authorize payment of medical benefits to the behavioral health provider below:

Signature: ____ Date: __________________

Printed Name: ____