CLIENT DATA

First Name	MI	Last Name		
Mailing address				
Phone(s)				
Email				
□ Male				
Primary Support Person(s):				
Date of Birth		Age		Social Security #
□ Employed □ full-time □ part-time □ othe □ Student □ full-time □ part-time □ othe □ Other				Name & address of employer or school:
FINANCIAL DATA Private-Pay				
Insurance Provider □ EAP □ Cigna □ Aetna □ BCBS □ Magellan				ame/DOB of insured: □ same as client
Insurance ID # Group ID #				
Phone # for benefits		Co-		re-Auth?
Emergency contact	& relationship		DA	··
ADMINISTRATIV Informed Conser Financial Respon	t for Treatment	S		 □ Consent to Use/Disclose PHI □ Copy of insurance card(s)
□ Release of Information □Declined □Primary MD □Psychiatrist □Family □Friend				
CLINICAL DOCUMENTS □ Treatment Plan □ Psychosocial hx □ Other assessments □ Symptom Checklist □ Self Assessments I-VII □ □ Family Charts				
Provider Signature_				
Annahal Agaa DhD	I DC/MHCD NC	C TN	I DC	C 2052 NDI 1407046056