Claremont Counseling and Support Center, A Psychological Corporation

Client Information

Client Name: _____ **Today's Date:** _____

Birthdate: __/__/__ Age_____ Gender _____ SS# ____-____-____ Driver's Lic.# _____

Street Address _____ City _____

State _____ Zip Code _____ Ok to mail follow-up letters to this address? ☐ Yes ☐ No

Cell No. (___)_____ Ok to call/msg? ☐ Yes ☐ No

Home/Other No. (___)_____ Ok to call/msg? ☐ Yes ☐ No

E-mail address _____ Ok to e-mail? ☐ Yes ☐ No

Employer/School _____ Occupation _____

Work No. (___)_____ Ok to call/msg? ☐ Yes ☐ No

Marital Status ☐ Single/Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Living Together? Other _____

How Long? _____ Spouse/Partner's Name _____

Previous Marriage? ☐ Yes ☐ No How Long? _____

Children Names/Ages_____

Emergency Contact_____ Phone No. (___)_____

Relationship to You _____ ok to call in an emergency? ☐ Yes ☐ No

Previous Counseling? Yes No Past Therapist(s) _____

How long? _____ Did you see a psychiatrist? ☐ Yes ☐ No Who? _____

Referred By_____ Phone No. (___)_____

Address _____ Ok to send thank you? ☐ Yes ☐ No

Have you or a family member been treated by anyone in our office before? ☐ Yes ☐ No

Who was treated? _____By whom? _____

Primary Physician_____ Date last seen_____

Physician's Phone No.(___)_____Physician's fax No. (___)_____

Release on file? ☐ Yes ☐ No Medical History _____

Current Psychiatrist _____ Date last seen _____

Release on file? ☐ Yes ☐ No Psychiatric History _____

Current Medications and dosages: _____

Insurance *Please bring your insurance card(s) to your first appointment*

Primary Insurance _____ Policy # _____

Insurance Phone No.(s) (___)_____ Group #_____

Subscriber's Name_____ Subscriber SS#/Member#_____

Subscriber's D.O.B._____ Deductible? Yes No Have you met Deductible? Yes No

Subscriber's Address _____

Do you have a Secondary Insurance? Yes No: _____

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Presenting Concern (s): Please describe your primary reason for seeking treatment at this time.

_____

Was there an event which caused these problems? ☐ Yes ☐ No If Yes, Please describe _____

_____

Please help us evaluate our services to you by rating the following:

	Excellent	Very Good	Good	Fair	Poor
Promptness of scheduling your appointment with your therapist	☐	☐	☐	☐	☐
Ease of getting to your therapist's office	☐	☐	☐	☐	☐

Financial Agreement and Authorization for Treatment

(Initial) _____ You have my permission to contact insurance to confirm benefits.

(Initial) _____ I give permission to my therapist to place my name on his/her mailing list so that I may be informed of upcoming events, services or resources. I understand the mailing list will not be given or sold to any other individual or agency.

(Initial) _____ You have my permission to treat me/my minor child.

(Initial) _____ I assign any insurance benefits to be paid to Claremont Counseling/ Chino Hills Counseling for services I receive and agree to pay any remaining balance not covered by insurance.

(Initial) _____ I understand that my therapist may be an intern and receiving supervision from Dr. Kari Halko-Weekes (Lic#PSY 22121). I give my permission for my case to be reviewed by Dr. Halko-weekes in benefit of my treatment.

(Initial) _____ I understand that all **CANCELLATIONS** must be made 24 hours in advance otherwise a charge of the full session fee will be applied.

Signature _____ **Date**_____

Party to take Financial Responsibility for Counseling (If same as patient indicate "self")

Name_____ Relationship _____

Address_____ Phone No. (___)_____

I agree to pay all charges for the above-listed client as shown by statements, promptly upon presentment, unless credit arrangements are agreed upon in writing. I agree to pay a $20 charge for each returned check.

Signature _____ **Date**_____