Martha A. Hines, MS, LMHC
Client Information

Today's Date:_____

Client Information:

Client Name:_____

Home Address:_____City:_____State:_____Zip:_____

Billing Address:_____

Contact Phone:_____Cell? Y/N Email:_____

Date of Birth:_____Current Age:_____ Education / Degree:_____

Other Participant DOB:_____Current Age:_____

Place of Employment:_____Title:_____

Marital Status:_____Name of Spouse:_____(M/F)

Children or other significant people sharing your home:

_____

Emergency Contact: Name:_____

Relationship to Client:_____Phone:_____Cell (Y/N)

Who referred you?_____

Insurance Information:

Insurance Company:_____Phone:_____

Address:_____

Subscriber Name and DOB:(if different than the client):_____

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Subscriber ID:_____Group #:_____

I authorize the release of any medical or other information necessary to process this claim.
I hereby assign payment of insurance benefits directly to Martha Hines, MS, LMHC, and I understand that the payment for services is ultimately my responsibility.

Client Signature:_____Date:_____

Print Name:_____

Responsible Party Sig: (if different than client)_____