**Blue Ash Counseling Center-Patient Information Sheet**

**General Information Date:**

Last Name First Middle Birthdate \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_

Sex \_\_\_\_\_\_M \_\_\_\_\_\_F Marital Status \_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone**: Home # (\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ May we leave a message? YES NO E-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell# (\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ May we leave a message? YES NO Work #(\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ May we leave a message? YES NO

**Insurance Information- Primary Insurance Authorization Number:**

Insured Last Name First Middle Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_

Telephone (\_\_\_)\_\_\_\_-\_\_\_\_­\_\_\_\_ Sex \_\_\_\_M \_\_\_\_F Marital Status \_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Insurance Phone # (\_\_)\_\_\_\_-\_\_\_\_\_\_\_Policy/Subscriber Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information – Secondary Insurance**

Insured Last Name First Middle Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_

Telephone (\_\_\_)\_\_\_\_-\_\_\_\_­\_\_\_\_ Sex \_\_\_\_M \_\_\_\_F Marital Status \_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Insurance Phone # (\_\_)\_\_\_\_-\_\_\_\_\_\_\_Policy/Subscriber Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Coordination of Care**

**It is important for your health care providers to speak to each other, so we may work together to help you. Please complete the information below and indicate your approval for us to coordinate care.**

**Primary Care Physician: Phone: Fax:**

**Address: City: State: Zip:**

**May we contact your physician Yes No I do not have a physician**

**Psychiatrist: Phone: Fax:**

**Address: City: State: Zip:**

**May we contact your psychiatrist Yes No I do not have a psychiatrist**

**Assignment & Release: I herby assign my insurance benefits to be paid directly to the undersigned therapist. I am financially responsible for non-covered services. I also authorize the therapist to release any information requested.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature or Authorized Parent/Guardian Date**