Client Information Form

Client Name: _____

Preferred Name: _____

Address: _____

Email: _____

Home Phone: _____ **Cellphone:** _____

Male: ☐ **Female:** ☐ **Age:** _____ **Date of Birth:** _____

Ethnicity: _____

SSN: _____

Insurance: _____

Marital Status: _____ **Spouses Name:** _____

Employer: _____

Work Status: **Full Time** **Part Time** **On-Call**

School: _____**Grade:**_____

Parent or Guardian (if under 18): _____

Medical History

Previous Mental Health Treatment/Counseling: _____

Current Medication(s): _____

Dose(s):_____

Directions: _____

Allergies and Reactions: _____

Current Over-the-Counter Products and Supplements: _____

_____

History of Psychotropic Medications Used and Reason for Discontinuation: _____

_____

Primary Care Provider: _____

Pharmacy: _____

Emergency Contact Information

Name: _____ **Relationship:** _____

Phone Number: _____

How did you hear about Open Range Counseling Center? (Please circle all that apply)

Friend/Relative	School	Facebook	Website
Physician/Clinic/Hospital	Workplace	Social Services	
Court/Attorney	Pastor/Clergy	Other: _____	

Reason for Visit: _____

Please mark how you would like to receive your statements:

_____ via Text _____ via Email _____ via Mail

I hereby authorize the release of any information necessary to process an insurance claim, including diagnosis.

I hereby authorize my health plan to remit payment directly to Open Range Counseling Center.

I acknowledge that I will be charged a $100 No-Show fee for every missed therapy appointment.

Due to the high demand for medical services offered, if you do not cancel your appointment within 24 hours prior to your scheduled appointment, you (not insurance) will be billed $150.00 for any missed appointment.

A Late Cancellation fee of $25 will be applied for all appointments cancelled less than 24 hours before your scheduled appointment.

If your new patient/intake paperwork is not completed within 24 hours of your medical appointment, we also reserve the right to cancel your appointment to fulfill scheduling demands.

I acknowledge that all co-pays and other client payment responsibilities are due at the time of services.

I acknowledge that Open Range nor its therapists will be held responsible for the confidentiality of information discussed while using electronic devices.

I acknowledged that I have received a copy of Open Range Counseling Centers Notice of Privacy Practices, Informed Consent for Psychotherapy and Telehealth. If I have questions or concerns, I should contact the office at, 135 Sims St, Suite 202, Dickinson, ND 58601 or call 701-264-9049.

_____ _____

(Signature) **(Date)**