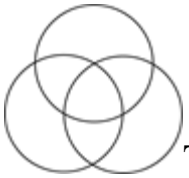


Trilogy Counseling Services

Client Information Sheet

Client Name:_____Date:_____

Address:_____City_____

State:_____Zip:_____Home Phone: _____Cell Phone:_____

Marital Status:_____ Sex:____Soc. Sec. #_____ Birth Date:_____Age:___

Person Financially Responsible:_____Relationship to Client:_____

Address: _____City:_____

State:_____Zip:_____Home Phone:_____Cell Phone:_____

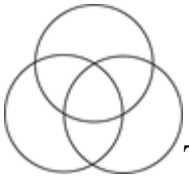
1st Insurance Carrier:_____Policyholder's Name:_____

1st Policyholder's Date of Birth:_____Social Security Number: _____

2nd Insurance Carrier:_____Policyholder's Name:_____

2nd Policyholder's Date of Birth:_____Social Security Number: _____

Responsible Party Email:_____



Trilogy Counseling Services

Client Assignment of Insurance Benefits and Authorization to Release Information

I acknowledge that I have received a copy of the patient bill of rights and grievance procedure and the informed consent for treatment form. I hereby agree to treatment and understand that should I have questions I will contact my therapist or the clinic staff.

I hereby authorize any insurance carrier to make payment directly to Trilogy Counseling Services, LLC, of any benefits otherwise payable to me for services provided by Trilogy Counseling Services, LLC. I understand that I am financially responsible for all charges whether or not paid by the said insurance.

I further authorize Trilogy Counseling Services, LLC to release to my insurance company(s) any information from my record which may be necessary to determine benefits payable under my policy. This information may include, but is not limited to diagnosis, treatment, procedure and/or photocopies of all or part of my record.

_____

Signature of Client Date:

_____

Signature of Parent/Guardian Date:

_____

Signature of Witness Date:

_____

Signature of Revocation Date: