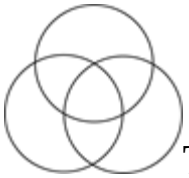

Trilogy Counseling Services

Therapist:_____
Diagnosis:_____

Client Information Sheet - CONFIDENTIAL

Date:_____
Client Name:_____
(Last) (First) (Middle Initial)
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:_____
1at Policyholder's Date of Birth:_____Social Security Number: _____-____-_____
2nd Insurance Carrier:_____Policyholder's Name:_____
2nd Policyholder's Date of Birth:_____Social Security Number: _____-____-____

I would like to receive email notifications to access my eStatement/eBill, securely online, and to pay bills I may owe online through www.MyProviderLink.com. By providing my email below. I am consenting to receive eStatement notifications and the option to make payments online. My email will not be shared for any other purposes and will remain confidential:

Responsible Party Email:_____

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

I further authorize Trilogy Counseling 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.

Client or Guardian Signature:_____