Integrity Counseling

Demographic/Insurance/HIPAA Update ï Minor

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person providing information _____ Date:_____

Please complete ENTIRE form

Clients Personal Information

Full Name (w/M.I.) _____ Prefer to be called _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Gender: ☐M ☐F Social Security No._____

Home Phone (___)_____ Work Phone (___)_____ Cell (___)_____

Best time to contact me _____ □ a.m. □ p.m. on my - □ Home phone □ Work phone □ Cell phone

Marital Status □ Single □ Married □ Widowed □ Separated □ Divorce □ Other _____

Email address _____

Employer _____ City _____ Phone _____ □Pt □Ft □Ret

Name of school (if applicable) _____ City/State _____

Referred by _____ **Emergency** Contact_____ **Phone #**_____

Parent/Guardian Information (if Client is a Minor) □ N/A

Parent / Guardian Name _____

Employer Name _____ Work Phone (___)_____

Employer Address _____ City/State _____ Zip _____

Child Is (Please check) □ My biological child □ My adopted child □ My foster child □ Other _____

Responsible Party (who will receive the statements?)

Name _____ DOB _____ SS # _____

Drivers License # _____

Phone (___)_____ Relationship to Client □ Self □ Spouse □ Parent □ Other _____

Address _____ City/State _____ Zip _____

Employer _____ Phone (___)_____ State _____

HIPAA

I, _____ acting on my own behalf, or on the behalf of a minor child (under the age of 14), of whom I have legal custody, do hereby give permission and authority to Integrity Counseling, LLC, to discuss my bill/statements with only the person or persons listed below, regardless of who makes payment on this account.

Name _____ Telephone# _____ Relationship _____

Name _____ Telephone# _____ Relationship _____

Name _____ Telephone# _____ Relationship _____

Name _____ Telephone# _____ Relationship _____

Name _____ Telephone# _____ Relationship _____

Name _____ Telephone# _____ Relationship _____

Primary Insurance Information (Who is the Policy Holder?)

Name of Insured _____ DOB _____ SS# _____

Address _____ City/State _____ Zip _____

Phone (___)_____ Relationship to Client □ Self □ Spouse □ Child □ Other _____

Employer _____ Address _____ Phone _____

Insurance Co _____ Subscriber# _____ Group# _____

Secondary Insurance Information (Who is the Policy Holder?)

Name of Insured _____ DOB _____ SS# _____

Address _____ City/State _____ Zip _____

Phone (___)_____ Relationship to Client □ Self □ Spouse □ Child □ Other _____

Employer _____ Address _____ Phone _____

Insurance Co _____ Subscriber# _____ Group# _____

☐ **I acknowledge the HIPAA authorization is in effect until I revoke it in writing.**

Client Signature _____ Date _____
(14 years and older, PLEASE sign)

Parent/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

Therapist Review

Signature _____ Date _____