Integrity Counseling

Demographic/Insurance/HIPAA Update – Adult

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 □ Divorced □ Other ___________________

Email address __________________________________

Employer ______________________________ City _____________ Phone ______________ □Pt □Ft □Ret

Name of school (if applicable) ________________________________ City/State __________________

Referred by _______________________ **Emergency** Contact_________________ **Phone #**________________

Guardian Information □ **N/A**

Guardian name ____________________________________ Phone ______________________________

(Please provide a copy of guardianship documents)

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, 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 understand t**he HIPAA authorization is in effect until I revoke it in writing.**

Client Signature ________________________________ Date ______________

Guardian Signature (if applicable)________________________________ Date ______________

Therapist Signature ________________________________ Date ______________

Therapist Review

Signature ________________________________ Date ______________