Life Balance Therapy
Tari Wilcox, LMFT

Client Registration Information:

Please complete this information:

Client Name: _____ Gender: _____
Nickname (if any): _____ Marital Status: ☐ Married ☐ Single ☐ Other _____
Birth Date: _____ Level of Education Completed: _____
Employment: ☐ Employed ☐ Student ☐ Unemployed Employer: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ ☐Cell ☐Home ☐Work Email: _____
Secondary Phone: _____ ☐Cell ☐Home ☐Work Email:_____
Spouse/Partner Name: _____ Birth Date: _____
Name/Location of Client's Psychiatrist/Physician: _____

Complete for each additional client:
First Name: _____ Birth Date: _____
Relationship to Client: _____ Level of Education Completed: _____
Employer: _____ Phone Number: _____
First Name: _____ Birth Date: _____
Relationship to Client: _____ Level of Education Completed: _____
Employer: _____ Phone Number: _____

Complete if client is a minor:
Caregiver's Name: _____ Birth Date: _____
Caregiver's Name: _____ Birth Date: _____

How did you hear about Life Balance Therapy?
☐ Internet ☐ Family/friend ☐ Provider (who?) _____
☐ Other: _____

Reason for seeking therapy services?
_____
_____
_____

What are your strengths?
_____
_____
_____

What are your goals of counseling?
_____
_____
_____

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Primary Insurance Information:
Insurance Type: _____ Relationship to Insured: _____
Insured's ID Number: _____ Birth Date of Insured: _____
Insured's Policy Group: _____
Insured's Employer/School: _____
Insured's Plan Name: _____
Effective Date: _____
Copay amount: _____
Deductible amount: _____
Responsible Party for Billing: _____

Secondary Insurance Information
Insurance Type: _____ Relationship to Insured: _____
Insured's ID Number: _____ Birth Date of Insured: _____
Insured's Policy Group: _____
Insured's Employer/School: _____
Insured's Plan Name: _____
Effective Date: _____
Copay amount: _____
Deductible amount: _____
Responsible Party for Billing: _____