COUNSELING CONNECTIONS, LLC
Client Profile

Information on this form is held in the confidence and will not be released without your written approval. Please fill out this form as thoroughly as possible. This form must be signed and dated in TWO places highlighted below.

Client/Child Name: _____ DOB: _____ Age:_____

Preferred Name: _____ Legal Gender (required): ☐Undefined ☐Female ☐Male

☐Transsexual M-F ☐Transsexual F-M ☐Non-binary ☐Other _____

(Optional) Gender Identity: ☐Undefined ☐Agender ☐Female ☐Gender fluid ☐Gender non-conforming ☐Gender queer ☐Intersex ☐Male ☐Non-binary ☐Trans Female ☐Trans Male ☐Two Spirit ☐Questioning ☐Choose not to disclose ☐Other _____)
(Optional) Sexual Orientation: ☐Undefined ☐Asexual ☐Bisexual ☐Gay ☐Heterosexual ☐Lesbian ☐Pansexual ☐Polysexual ☐Queer ☐Questioning ☐Choose not to disclose ☐Other _____)
(Optional) Preferred pronouns: _____

Address (NO PO Box) _____City: _____ State: ____ Zip:_____

Best way to contact you: Home Phone: _____ Cell Phone: _____

SS# _____Employer or School:_____

(Legal guardian: _____ Phone if different: _____)

May we leave a message or reminder calls at phone # given? ☐Yes ☐No, best way to get message to client:

_____

Email address: _____

Emergency contact name: _____ Phone: _____

Relationship to client: _____

Responsible Party / Financial Information / Receipt of Privacy Practices

Insured's name: (if different than client) _____
Relationship to client:_____ DOB: _____
Address (if different)_____
Employer: _____
Name/Type of Insurance: _____
ID/Policy #: _____ Group #: _____
Primary Care Physician: _____ Approximate date last seen _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read and understand all the information provided to me and have completed the answers. I authorize Counseling Connections, LLC, to bill my insurance company for services rendered. If I choose not to use my insurance, or do not have any, then I will be responsible for payment at time of service. I understand that most insurances as well as Medicare require a copay that I will be required to pay at time of service and that payment plans may be available. If this is court related and I need documents for the court, I understand that I must have a zero balance on my account to receive such documents from my therapist.

Client/guardian signature: _____

I/We consent that the client named above may be treated at Counseling Connections, LLC. I/We have been provided a copy of the Informed Consent and the HIPAA/Notice of Privacy Practices and understand the information.

_____ _____

Signature of Client/ Guardian Date