# Client Information Sheet

(Please Print)

First Name _____ MI _____ Last Name _____ SS#_____

Age _____ Date Of Birth _____ Gender: ☐ Male ☐ Female

Legal Guardian: _____
(If client is a minor) _

Biological Parent Marital Status:
❑ Married ❑ Never Married*
❑Divorced* ❑Separated Divorcing*

*If not married or divorcing, please give second parent information below.

| Address | City | State | Zip |
|---|---|---|---|
| Home Phone ☐ Please do not leave a message. | Cell Phone ☐ Please do not leave a message. | | |
| Email ☐ Please do not send a message. | | | |
| Employer | Work Phone ☐ Please do not leave a message. | | |
| Emergency Contact | Phone | Relationship | |
| *Non-Custodial/Shared Parent Name: (if child does not live with both parents) | *Phone | ❑ *Check if unknown | |
| *Address | *City, State | *Zip | |

## Billing Information

| Insurance/EAP Carrier *(For mental health benefits)* | Member ID | Employer |
|---|---|---|
| Primary Policy Holder: (If other than client) | DOB | SS# |

☐ **I have contacted my insurance company and understand my mental health benefits**
(Please note we are not responsible for this information)

My Counselor Is: ☐ In Network ☐ Out of Network With My Insurance Carrier

**Please fill in all sections.** **Check box if using EAP sessions.** ❑

Authorization Number_____ Dates: _____to_____

Number of Sessions Authorized_____ EAP Name_____

Where did you hear about us?_____ ☐ Please check if we may contact your referral source

☐ **Please check here if you would like billing or other correspondence sent to a different address.**
(Please ask for alternate mailing address form)

I agree that the insurance information I have provided is true and correct to the best of my knowledge. I understand it is my responsibility to obtain the initial authorization from my insurance company. If I fail to do so, I understand that I will owe full fee for services. I also understand that it is my responsibility to notify Arbor Counseling, LLC immediately of any changes in policy or benefit status. My signature indicates understanding and acceptance of the office policies presented and my responsibility for the payment of any incurred fees.

Signed_____ Date_____