Client Information Sheet

Please fill out completely. Thank you.

Co-Pays are due at each session.

CLIENT

Last Name _____ First Name _____ Middle Initial _____

Home Phone_____ Cell Phone_____

If Minor - Parent's Information needs to be completed on back.

Street Address _____

City _____ State _____ Zip _____

Date of Birth _____/_____/_____ Gender M___ F___ Email_____

Referred by_____

PRIMARY INSURED'S INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Street Address _____

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth ____/____/_____ Gender M___ F___ Phone Number _____

Social Security # _____ **Employer** _____

Name of Insurance Company _____

Insurance ID # _____ **Insurance Group #** _____

Driver's License Information: State_____ **Number**_____

Relationship to client: _____

Patient or Authorized Person pertaining to the above patient's medical payments/information: I authorize the release of any medical or other information necessary to process claims for services provided. I authorize payment of medical benefits to LifeSpring Counseling Services, PLLC. **I am responsible to pay any copays or deductibles to LCS.**

Signature:_____**Date:**_____

Please complete the back side if applicable to you.

PARENT/GUARDIAN/RESPONSIBLE PARTY

Last Name _____ First Name _____ Middle Initial _____

Home Phone _____ Cell Phone _____

Street Address _____
(If different from client)

Mailing Address _____Email_____

City _____ State _____ Zip _____

Date of Birth _____/_____/_____ Gender M___ F___ Marital Status _____

Social Security # _____ **Employer** _____

Driver's License Information: State:_____ **Number:**_____

Relationship to client: _____

SECONDARY INSURED'S INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Street Address _____
(If different from client)

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth ____/____/_____ Gender M___ F___ Phone Number _____

Social Security # _____ **Employer** _____

Name of Insurance Company _____

Insurance ID # _____ Insurance Group # _____

Relationship to client: _____

For Office Use Only

Therapist's Signature _____ Date _____

Diagnosis 1. _____.___ 2. _____.___ Private Pay/No Insurance Rate_____