WELLSPRING COUNSELING

CLIENT INFORMATION FORM

********* Please Print *********

First Appointment: _____ Today's Date: _____

CLIENT INFORMATION:

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____ Email _____

Ok to leave message at: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Employer: _____ Student: _____

In the event of an emergency WellSpring may contact: _____

Relationship: _____ at phone number ( )_____

RESPONSIBLE PARTY PERSONAL INFORMATION (Guarantor):
(Do not complete this section if the Responsible Party information is the same as the client information)

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____ City:_____ State: ____ Zip Code: _____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____ Ok to leave message at: _____

PRIMARY INSURANCE INFORMATION:
(You must complete this section and present a copy of your insurance card for insurance to be billed)

Insurance Company: _____

Phone Number: ( )_____

INSURED PERSONAL INFORMATION (Subscriber):

Relationship to Client: _____ Employer: _____

I.D. #: _____ Group #: _____

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____

I authorize the release of any information necessary to process claims with my insurance company and I authorize my insurance company to make payments for my treatment directly to WellSpring. I understand that it is my responsibility to contact my insurance company to find out what my benefits are and to also see if I have a copay and/or deductable. I understand that I am responsible for paying my deductible or co-pay (where applicable). We will release information to the WellSpring billing person for the purposes of billing.

Signature _____ Date _____

I acknowledge receipt of a copy of HIPPA practices for WellSpring.

Signature _____ Date _____

I authorize WellSpring to contact my emergency contact person if the need would arise. I authorize WellSpring to send me appointment email reminders.

Signature _____ Date _____

PLEASE NOTE: We **do not** bill secondary insurance. If you choose to submit on your own, you must use the Explanation of Benefits statement sent by the primary insurance company to your address.