

**Couple Information**

Date \_\_\_\_\_

1) Client \_\_\_\_\_

2) Client \_\_\_\_\_

Single     Married     Co-habit     Divorced     Separated     Widowed

1) Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Soc.Sec.# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

Preferred contact (check as many as you wish)     Home     Work     Cell     Email

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How long \_\_\_\_\_

2) Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Soc.Sec.# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

Preferred contact (check as many as you wish)     Home     Work     Cell     Email

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How long \_\_\_\_\_

**Referred by** \_\_\_\_\_

**Person to contact in emergency**

Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

**Insurance Information**

Insured Person \_\_\_\_\_

Soc.Sec.# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insured ID# \_\_\_\_\_

Policy/Group# \_\_\_\_\_

Insurance Telephone \_\_\_\_\_

**In signing this agreement my signature acknowledges that I fully agree to and accept the following conditions:**

I authorize the release of medical or treatment information necessary to process my insurance claim including the release of a mental or chemical dependency diagnosis.

I accept full responsibility for payment should my insurance carrier not reimburse for services rendered. I understand and accept all financial responsibility for treatment.

1) Client Signature \_\_\_\_\_ Date \_\_\_\_\_

2) Client Signature \_\_\_\_\_ Date \_\_\_\_\_