FAMILY COUNSELING CENTER
REGISTRATION HISTORY

ABOUT THE CLIENT (ADULT OR CHILD)

Today's Date:_____

Client's Name:_____ **Birthdate**: _____

What do you prefer to be called:_____Previous Names _____

Social Security # _____ ___ Male ___Female

____ Minor ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed

Street Address: _____

City _____ **State** _____ **Zip** _____ **Phone** #_____

Employer:_____ How Long Have You Worked There?_____

Employer Address:_____ **Work #:**_____

Spouse's Name:_____

Spouse's Birthdate:_____ Spouse's Social Security #_____

Whom may we thank for referring you:_____

Reason for Visit Today:_____

Previous Counseling?_____When:_____ Where:_____

CHILD INFORMATION (if client is a child)

Child's School:_____ Child's Interests:_____

Name of person living with:_____ Relationship to child:_____

Who will be responsible for the account?_____

Biological or Adopted Father's Name_____Home Phone #_____

Address:_____ City_____ State _____ Zip _____

Father Employed By:_____ Employer's #_____

Father's Social Security #_____ Father's Birthdate:_____

Physical Custody _____ Yes _____ No **Legal Custody** _____ Yes _____ No

Biological or Adopted Mother's Name:_____ Home Phone #_____

Address:_____ City_____ State _____ Zip _____

Mother Employed By:_____ Employer's #_____

Mother's Social Security #_____ Mother's Birthdate:_____

Physical Custody _____ Yes _____ No **Legal Custody** _____ Yes _____ No

Other children in family(Names & Ages):

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

IN EVENT OF EMERGENCY

Whom should we contact:_____ Relationship to Patient?_____

Home Phone #_____ Work Phone #_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____ Phone#_____

Identification #_____ **Group or Plan** #_____

Primary Insured's Name:_____ **Relationship to Patient**:_____

Primary Insured's Birthdate _____ Social Security #_____

Insured's Employer:_____

PLEASE SEE BACK SIDE OF FORM FOR SIGNATURES.

SECONDARY INSURANCE INFORMATION

Insurance Company:_____ Phone#_____
Identification #_____ Group or Plan #_____
Primary Insured's Name:_____ **Relationship to Client**:_____
Primary Insured's Birthdate _____ Social Security #_____
Insured's Employer:_____

HEALTH HISTORY

Are you taking any medications?_____ If so, list them:_____
Date of last health care exam?_____ For What Reason?_____
Have you been hospitalized in the last 5 years?_____ If so, for what?_____
This form was completed by: _____

I have received a copy of the Notice of Privacy Practices.

I give consent to the treatment and assessment of me or my child.

No audio or videotaping of therapy sessions without prior written consent of the therapist and client.

APPOINTMENT CONFIRMATION CALLS

I authorize Family Counseling Center to leave messages at the number listed on this form and to mail correspondence to the address listed on this form.

Signature:_____Date:_____

READ AND SIGN THE FOLLOWING STATEMENTS

RELEASE

I authorize the release of the following information to my insurance company which is necessary to process any claims for a time period not to exceed one year following the termination of service and will include only the following information: **DIAGNOSIS, NUMBER & DATES OF SESSIONS, TREATMENT STRATEGY.**

ASSIGNMENT OF BENEFITS

I hereby authorize Family Counseling Center the medical benefits, if any, otherwise payable to me for the services to be regularly billed by The Family Counseling Center on my account. A Photocopy of this authorization may be honored.

PATIENTS
RELEASE & GUARANTEE

I authorize the release of the following information to Medical Assistance which is necessary to process any claims for a time period not to exceed one year following the termination of service and will include only the following information: **DIAGNOSIS, NUMBER & DATES OF SESSIONS, TREATMENT STRATEGY.** I agree that if Medical Assistance does not pay for the charges incurred or to be incurred, that I will be responsible for the charges.

Date:_____ Patient or Parent (if minor):_____