Appointment Date: ____/____/_____
Therapist: ___________________ **Client Number:** __________

Have you previously received services from our agency?
ð Yes ð No If so, when? ______________________

Please indicate if you plan to use the following:
ð Employee Assistance Program ð Medicare ð Medicaid
ð Insurance

Client Information

Name: ____
First *MI* *Last*

Address: ____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Home Phone: ______________________ Cell Phone: ______________________
Preference: ð Home ð Cell

Birth Date: ______________________ Email: ______________________

School or Employer: ____

Social Security #: ________________ Sex: ð M ð F Marital Status: ______________________

Spouse/Partner OR Legal Guardian (if client is a minor)

Name: ____
First *MI* *Last*

Address: ____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Home Phone: ______________________ Cell Phone: ______________________
Preference: ð Home ð Cell

Birth Date: ______________________ Email: ______________________

Employer: ____

Social Security #: ________________ Relationship to Client: ______________________

Family Members / Others Living in Household

Name	*Relationship to Client*	*Age*	*School or Employer*

Medical Information

Primary Physician: ____
Current Medications: ____
Presenting Concern (Optional): ____

Referral Source

Name of Referral: ____
ð Attorney ð Physician ð Mental Health Professional ð Friend/Relative ð Website ð Employer
ð Employee Assistance Program ð Court ð Other

Employee Assistance Program

Sioux Empire Christian Counseling contracts with various companies who provide employee assistance programs to their employees and immediate family members. If your employer participates in this type of program, you are entitled to receive a limited number of services at no charge to you. If your employer does not currently offer this type of benefit, we encourage you to speak to your human resource representative about the possibility of implementing an EAP.

Employee Name: ___________________________________ Relationship to Client: ____________________

EAP Name: _______________________________________ Authorization Number: ____________________

EAP Address: ____
Street *City* *State* *Zip Code*

EAP Phone: ____________________________

The EAP company name, address, phone number and authorization number are required for billing.

Primary Insurance

Name of Insurance Company: ____

Card Holderǫs Name: ______________________________ Relationship to Client: ___________________________

Card Holderǫs Social Security Number: ________________ Card Holderǫs Birth Date: _________________________

Identification Number: _____________________________ Group Number: _________________________________

Have you received pre-authorization if required? ð Yes ð No ð Not Applicable

Pre-authorization is your responsibility. Sioux Empire Christian Counseling will provide necessary treatment information when requested by the insurance company.

Secondary Insurance

Name of Insurance Company: ____

Card Holderǫs Name: ______________________________ Relationship to Client: ___________________________

Card Holderǫs Social Security Number: ________________ Card Holderǫs Birth Date: _________________________

Identification Number: _____________________________ Group Number: _________________________________

Have you received pre-authorization if required? ð Yes ð No ð Not Applicable

Pre-authorization is your responsibility. Sioux Empire Christian Counseling will provide necessary treatment information when requested by the insurance company.

Person Responsible for the Account

Name of Individual or Agency: ____

Address: ____
Street *City* *State* *Zip Code*

Phone: _______________________________ Has written authorization been provided? ð Yes ð No ð Not Applicable

Assignment and Release

I authorize the release of any information relating to claims for benefits submitted on behalf of myself and /or my dependent. I further expressly agree and acknowledge that my signature on this document authorizes Sioux Empire Christian Counseling to submit claims for services rendered. I further authorize insurance companies and other third party payers to make payment directly to Sioux Empire Christian Counseling.

____

Client or Legal Guardian Signature *Date*