

Counseling for Wellness, L.L.P.  
420 West Main Street  
Kent, Ohio 44240

Client Name \_\_\_\_\_ S. S. Number \_\_\_\_\_

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

Birthday \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status \_\_\_\_\_

Home # ( ) \_\_\_\_\_ Business # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Okay to call at work ( ) Yes ( ) No Referral Source \_\_\_\_\_

**EMPLOYMENT INFORMATION (Insurers)**

Name of Insured \_\_\_\_\_ Employers Name \_\_\_\_\_

Employers \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone ( ) \_\_\_\_\_ Fax # ( ) \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Relationship to Client \_\_\_\_\_

**AUTHORIZATIONS (PLEASE SIGN)**

I hereby authorize my provider to release any information acquired in the course of my treatment to my insurance company if needed for payment

Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize payment directly to my provider of medical benefits. I understand I am financially responsible for any deductibles, co-payments, or any amounts not covered by my insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**EMERGENCY CONTACT/NAME** \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

DSM Code \_\_\_\_\_ Counselor \_\_\_\_\_