MW COUNSELING

Client Information:

Today's Date:_____

☐ New Client
☐ Returning Client (Returning would be if it has been more than 3 months since you were seen)

Name: (L, F, MI)_____Age:_____
Address:_____
City:_____State:_____ Zip Code:_____ DOB:_____
Phone:_____Can a message be left? Yes/No Can this number receive text messages? Yes/No
Email:_____ Would you like appointment reminders via text? Yes/No
Name of Cell Phone Carrier:_____

Gender: Male/Female
Marital Status: Single/Married/Divorced/Legally Separated/Widowed
Are you a student? Yes/No Name of School:_____Grade:_____
Employer:_____
Occupation:_____
Primary Physician:_____Clinic:_____
Who referred you?_____

Emergency Contact:
In the event of an emergency, I give MW Counseling, LLC the right to contact the following person/people:
Name:_____ Relationship:_____
Emergency Contact's Phone:_____
Name:_____ Relationship:_____
Emergency Contact's Phone:_____

Responsible Party (Complete if primary client is under 18 or if the primary client is above 18 and is seeking services under a parent's health insurance)
Name: (L, F, MI)_____Age:_____
Address:_____
City:_____State:_____ Zip Code:_____ DOB:_____
Phone number:_____Can a message be left? Yes/No
Can this number receive text messages? Yes/No Email:_____
Gender: Male/Female **Relationship to Client:**_____SSN:_____-_____-_____
Employer:_____Occupation:_____

Primary Insurance Company:_____
Insurance Address:_____
Subscriber or ID #:_____Group/File #:_____
Full Name of Policy Holder:_____DOB:_____
Employer:_____Relationship to client:_____
Home address if different than client:_____
Phone Number of the policy holder:_____
Deductible:_____Deductible been met? _____Co-payment:_____
Co-Insurance:_____Mental Health Coverage Limits_____
Is referral/pre-authorization required: Yes/No Has pre-authorization been obtained? Yes/No
Terms of the referral:_____

Secondary Insurance Company:_____
Insurance Address:_____
Subscriber or ID #:_____Group/File #:_____
Full Name of Policy Holder:_____DOB:_____
Employer:_____Relationship to client:_____
Home address if different than client:_____
Deductible:_____Co-payment:_____Mental Health Coverage Limits_____
Is referral/pre-authorization required: Yes/No Has pre-authorization been obtained? Yes/No
Terms of the referral:_____