CHRISTIAN LIFE COUNSELING

CONFIDENTIAL INFORMATION

Today's date _________________

Patient's Name ____ Date of Birth _______________________________

Address ____City ______________________ Zip Code __________________

Home Phone No. ___________________ Cell Phone No. _________________________ Other Phone No. ___________________________________

E-mail Address ______________________________ Sex F/ M Single Married Widowed Divorced If student: Full-time Part-time

Insurance Information

Insurance Carrier ________________________ Employer ___________________________________ Group No. __________________________

Policy No. _________________________ Insured's Name ____

Insured's Date of Birth ______________ Insured's Social Security No. ____________________ Insured's relationship to patient _________________

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If Patient Is A Minor

Father's Name ___________________________ Date of Birth ______________ Home Address ____

Mother's Name ___________________________ Date of Birth ________________ Home Address ____

Name of Responsible Party _________________________________ Relationship to Patient ____

Address ____

Home Phone No. _______________________ Cell Phone No. _____________________________ Office Phone No. _________________________

Spiritual

Church Affiliation ____ Pastor 's Name ____

1. **I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made with the Accounting Department.**
2. **AUTHORIZATION TO RELEASE INFORMATION: I herby authorize the release of any information regarding my/my child's condition or treatment to my insurance company.**
3. **AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.**

SIGNED (patient, or parent if patient is minor) __________________________________ DATE: ______________________________