Counseling Request Form

Patient Name: _____
First Last

Address/Zipcode:_____
Street City/Town Zipcode

DOB: ____/____/_____ **Male or Female**

If applicable, parent or guardian: _____

Contact Phone: (_____)_____-_____ **Circle one: Mobile or Landline**

Name of Insurance Co: _____ **2nd Ins:** _____

Phone Number on the back of your insurance card: (_____)_____-_____

You are responsible for contacting Member Services on the back of your insurance card to confirm the possible copay or deductible payment due before each visit.

When are you available for appointments? (Circle all that apply)

Morning Mid-Day Evening Mon Tue Wed Thur Fri Sat Anytime

TYPES AND TOPICS
(Circle all that apply)

INDIVIDUAL COUPLES FAMILY ANXIETY DEPRESSION LOSS TRAUMA

ILLNESS DIVORCE ANGER MANAGEMENT SUBSTANCES DOMESTIC VIOLENCE OTHER

********** **OFFICE USE ONLY BELOW THIS LINE** **********

Today's Date: ____/____/2019 **Provider:** ____ **Ins. Subscriber:** _____**DOB:**_____

Ins ID#: _____ **EAPs**: Y N Auth#: Sessions#:

2nd Ins ID#:_____

Insurance Benefits Confirmed:

Effective Date: CoPay: $ CoIns: % Dedctbl Paymnt: $ .00

Deductible: Ind $ Fam $ Met/Not Met Sessions: Auth After No Auth

Auth #: Auth Start Date: / / Sessions Per Year:

Benefit Year: 1-1 to 12-31 7-1 to 6-30 10-1 to 9-30

Date & Time of 1st Appt

____/____/2019

____:_____
AM PM