Agape Christian Counseling Center

CLIENT INFORMATION

(PLEASE PRINT)

Today's Date: _____

Client Name:_____ _____ _____
First *Middle* *Last*

Preferred Name: _____ Date of Birth: _____ Age:_____
Address 1: _____
Address 2:_____
Zip:_____ City/State: _____

Mobile Phone: _____ May We Leave a Message at This Number?_____
Home Phone:_____ May We Leave a Message at This Number?_____
Work Phone:_____ May We Leave a Message at This Number?_____
Other Phone:_____ May We Leave a Message at This Number?_____
Employer/School & Grade:_____

Please fill out ONLY 1: Insurance information or EAP information. ***PLEASE NOTE: We do not bill secondary insurance. If you submit on your own, you must use the Explanation of Benefits statement sent by the primary ins. company to your address.***

Insurance Provider:_____ ID#:_____ Group#: _____
Client's SSN:_____-_____-_____ (If client is a minor) Guarantor's SSN:_____-_____-_____
EAP Provider: _____ EAP Auth. #:_____ # of sessions approved:____

IN THE EVENT OF AN EMERGENCY, ACCC may contact: _____
Relationship to Client: _____ Phone Number:_____

RESPONSIBLE PARTY (GUARANTOR) PERSONAL INFORMATION: ***only if different than client***
Legal First Name:_____ MI:_____ Last Name:_____
Relationship to Client:_____ Date of Birth:_____ ☐Address Same As Above
Address:_____ City: State: _____ Zip Code:_____

☐Same As Above Mobile Phone:_____ Leave messages? ☐Yes ☐No
☐Same As Above Home/Work Phone:_____ Leave messages? ☐Yes ☐No
☐Same As Above Email Address:_____ Appt Reminders? ☐Yes ☐No

I authorize the release of any information necessary to process claims with my insurance company. I authorize my insurance company to make payments for my treatment directly to Agape Christian Counseling Center. I understand that I am responsible for paying my deductible/co-pay (where applicable). I understand a third party is used for this purpose. I authorize the release of information to the designated third-party biller for the purposes of billing.

Client/Parent/Guardian Signature:_____Date:_____