



**Primary Insurance Information** (All areas marked with a \* MUST be completed)

\*Insurance Company Name: \_\_\_\_\_

Insurance Company Phone #: (\_\_\_\_\_) \_\_\_\_\_

\*Subscriber's Name (if different): \_\_\_\_\_

\*Subscriber's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Relationship to Client: \_\_\_\_\_

\*Subscriber's Employer: \_\_\_\_\_

\*Subscriber's Insurance ID#: \_\_\_\_\_

\*Subscriber's Group Policy/ID #: \_\_\_\_\_

\*Subscriber's Phone # (if different): (\_\_\_\_\_) \_\_\_\_\_

\*Subscriber's Address (if different):

\_\_\_\_\_  
Street City State Zip

\*Co-Payment Amount (Payment is required at appointment time): \$ \_\_\_\_\_

\*Does the Client have an "Out-of-pocket deductible" for counseling? (circle one): Yes No

\*Does the Client require a "Pre-Authorization" before counseling begins?(circle one): Yes No

Pre-Authorization Code (Provided by subscriber's insurance company): \_\_\_\_\_

**Family Information** (All areas marked with a \* MUST be completed)

Immediate Family Members :

\*Spouse's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
First MI Last

Spouse's Employer: \_\_\_\_\_

Spouse's Business Phone #: (\_\_\_\_\_) \_\_\_\_\_

\*Children/Siblings (First names & ages only):

\_\_\_\_\_  
\_\_\_\_\_

\*Other Extended Family Members Living With Client:

Name: \_\_\_\_\_ \*Relationship to Client: \_\_\_\_\_

Name: \_\_\_\_\_ \*Relationship to Client: \_\_\_\_\_

**Emergency Contact Information** (All areas marked with a \* MUST be completed)

\*Name: \_\_\_\_\_ \*Relationship to Client: \_\_\_\_\_

\* Contact Phone #1: (\_\_\_\_\_) \_\_\_\_\_

\* Contact Phone #2: (\_\_\_\_\_) \_\_\_\_\_

\*Emergency Address:

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Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Secondary Insurance Information** (All areas marked with a \* MUST be completed)

\*Insurance Company Name: \_\_\_\_\_

Insurance Company Phone #: (\_\_\_\_\_) \_\_\_\_\_

\*Subscriber's Name (if different): \_\_\_\_\_

\*Subscriber's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ \*Relationship to Client: \_\_\_\_\_

\*Subscriber's Employer: \_\_\_\_\_

\*Subscriber's Insurance ID#: \_\_\_\_\_

\*Subscriber's Group Policy/ID #: \_\_\_\_\_

\*Subscriber's Phone # (if different): (\_\_\_\_\_) \_\_\_\_\_

\*Subscriber's Address (if different):

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Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Mental Health Information** (All areas marked with a \* MUST be completed)

\*Reason(s) for seeking counseling (circle all that apply):

- |                |                   |                 |
|----------------|-------------------|-----------------|
| ADD/ADHD       | Depression        | Panic Attacks   |
| Anger          | Employment        | Phobias         |
| Anxiety        | Family            | Self Harm       |
| Children       | Gender            | Sexuality       |
| Chronic Pain   | Grief/Bereavement | Stress          |
| Compulsions    | Medically Related | Substance Abuse |
| Couple/Marital | Obsessions        |                 |

Other Issues (please specify): \_\_\_\_\_

\*How long ago did the Client first experience the issue they are seeking counseling for?: \_\_\_\_\_

\* Periods of prior counseling and/or psychiatric hospitalizations (if applicable): \_\_\_\_\_

\*Prescribed Mental Health Medications:

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

**Physical Health Information** (All areas marked with a \* MUST be completed)

\*Does the Client have a Primary Care Physician(circle one): Yes No

\*Primary Care Physician's Name: \_\_\_\_\_

\*Primary Care Physician's Phone #: (\_\_\_\_\_) \_\_\_\_\_

\*Is the Client currently experiencing any chronic physical issues or limitations (circle one): Yes No

Briefly explain any physical

issues: \_\_\_\_\_

\*Does the Client smoke or use tobacco products?(circle one): Yes No How much per day?: \_\_\_\_\_

\*Does the Client drink alcohol regularly?(circle one): Yes No How many drinks per day?: \_\_\_\_\_

\*Prescribed Physical Health Medications:

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

\*I hereby certify that the subscriber listed in this document has active behavioral health coverage with \_\_\_\_\_ Insurance Company. My signature below is providing express consent to assign all insurance benefits from this company, in relationship to this treatment, otherwise payable to me, directly to Jane Mckinney and/or A Balanced Life LLC .

I further understand that if the subscriber's behavioral health coverage is denied or terminated during the course of treatment, I am completely responsible for all payments of any services rendered. This includes co-payments and deductibles that are not reimbursed through the subscriber's insurance policy. I hereby authorize Jane Mckinney and/or A Balanced Life LLC to release all information necessary to secure the payment of benefits. I authorize the use of the signature below on all insurance. submissions, whether manually or electronically.

\*Client (or guardian) printed name: \_\_\_\_\_

\*Client (or guardian) signature: \_\_\_\_\_ Date: \_\_\_\_\_