

A Balanced Life LLC New Client Information Form

(For the clinician) Name of clinician:					
Please make a copy of the front and ,attach to this form.	and back	of the clie	ent's insu	rance card an	d I.d.;
Please ask client to complete the and attach to this form.	e billing (agreement	and cred	lit card autho	rization form
<u>For the client:</u> Please provide the following provider at your first appointment.	ng inform	nation and	return th	is completed	form to your
Personal Information (All areas marked with	າ a * MUST	be complete	d)		
*Client's Legal Name:			1	Nickname:	
* Client's Home Address:		Last			
Street	City			State Zi	p
* Client's E-mail Address:		@			_
Client's Home Phone #: ()					
Client's Business Phone #: ()					
* Client's Main Cell Phone #: ()					
Other Important Phone #: ()			*Type of	# ?:	
* Client's Date of Birth://	Age:				
* Client's Gender (circle one): Female	Male	N	on-Binary		
* Client's Marital Status (circle one): Single		Married			
Other (Ot	her includ:	es Divorced	, Widowed	& Domestic Pa	rtnerships)
* Client's School OR Work Status (circle only on	e):	F/T Stude	ent	P/T Student	OR
		Employed	i	Not Employed	

Primary Insurance Information (All	areas marked wit	h a * MUST be com	npleted)	
*Insurance Company Name:				
Insurance Company Phone #: ()				
*Subscriber's Name (if different):				
*Subscriber's Date of Birth://	*Relations	nip 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 de	eductible" for cou	unseling? (circle o	ne): Yes No	
*Does the Client require a "Pre-Authorizati	on" before couns	eling begins?(cird	cle one): Yes	No
Pre-Authorization Code (Provided by subsc	riber's insurance	company):		
Family Information (All areas marked v Immediate Family Members :	vith a * MUST be	completed)		
*Spouse's Name:				Age:
	MI	Last		
Spouse's Employer:				
Spouse's Business Phone #: ()_				_
*Children/Siblings (First names & ages onl	.y):			
*Other Extended Family Members Living W	 /ith Client:			
Name:		*Relationship to	Client:	
Name:		*Relationship to		

		T be completed)			
*Name:	*Relationship to Client:				
* Contact Phone #1: ()				
* Contact Phone #2: ()				
*Emergency Address:					
Street	City	State Zip			
Secondary Insurance I	nformation (All areas marked with a * M	UST be completed)			
Insurance Company Name:					
Insurance Company Phone	#: ()				
*Subscriber's Name (if diffe	rent):				
	/*Relationship to Clie				
	:				
	 ID #:				
	fferent): ()				
*Subscriber's Address (if dif	ferent):				
 Street	City	State	Zip		
Street	City	State	Zip		
	City I †ion (All areas marked with a * MUST be		Zip		
Mental Health Informa	·		Zip		
Mental Health Informa 'Reason(s) for seeking coun	t ion (All areas marked with a * MUST be		Zip		
Mental Health Informa *Reason(s) for seeking coun ADD/ADHD	Ition (All areas marked with a * MUST be seling (circle all that apply):	e completed)	Zip		
Mental Health Informa *Reason(s) for seeking coun ADD/ADHD Anger	I fion (All areas marked with a * MUST be seling (circle all that apply): Depression	e completed) Panic Attacks	Zip		
Mental Health Informa *Reason(s) for seeking coun ADD/ADHD Anger Anxiety	I fion (All areas marked with a * MUST be seling (circle all that apply): Depression Employment	e completed) Panic Attacks Phobias	Zip		
Mental Health Informa *Reason(s) for seeking coun ADD/ADHD Anger Anxiety Children	I fion (All areas marked with a * MUST be seling (circle all that apply): Depression Employment Family	e completed) Panic Attacks Phobias Self Harm	Zip		
Mental Health Informa *Reason(s) for seeking coun ADD/ADHD Anger Anxiety Children Chronic Pain	Ition (All areas marked with a * MUST be seling (circle all that apply): Depression Employment Family Gender	Panic Attacks Phobias Self Harm Sexuality	Zip		
Mental Health Informa *Reason(s) for seeking coun ADD/ADHD Anger Anxiety Children Chronic Pain	Ition (All areas marked with a * MUST be iseling (circle all that apply): Depression Employment Family Gender Grief/Bereavement	Panic Attacks Phobias Self Harm Sexuality Stress	Ziţ		
*Reason(s) for seeking coun ADD/ADHD Anger Anxiety Children Chronic Pain Compulsions Couple/Marital	Ition (All areas marked with a * MUST be iseling (circle all that apply): Depression Employment Family Gender Grief/Bereavement Medically Related	Panic Attacks Phobias Self Harm Sexuality Stress Substance Abuse	Zip		
Mental Health Informa *Reason(s) for seeking coun ADD/ADHD Anger Anxiety Children Chronic Pain Compulsions Couple/Marital Other Issues (please specify	Ition (All areas marked with a * MUST be aseling (circle all that apply): Depression Employment Family Gender Grief/Bereavement Medically Related Obsessions	Panic Attacks Phobias Self Harm Sexuality Stress Substance Abuse	_		

	l Health Medications:		
Name:	Dosage:	Frequenc	y:
Name:	Dosage:	Frequenc	y:
Physical Health	n Information (All areas	marked with a * MUST be c	ompleted)
*Does the Client I	have a Primary Care Phys	ician(circle one): Yes No	
*Primary Care Ph	ysician's Name:		
*Primary Care Ph	ysician's Phone #: ()	
*Is the Client curr	ently experiencing any ch	ronic physical issues or lim	nitations (circle one): Yes No
Briefly explain an	y physical		
issues:			
			How much per day?:
	·	,	ny drinks per day?:
	ical Health Medications:	0.0 0.10). 100 110 110 11 111a.	., a.i.i.o por day
-		Dosage:	Frequency:
Name.		Dosage	i lequelicy
Name:		Dosage:	Frequency:
Name:		Dosage:	Frequency:
Name:		Dosage:	Frequency:
			behavioral health coverage with
express consent	to assign all insurance ber	nefits from this company, ir	relationship to this treatment,
otherwise payable	e to me, directly toJa	ne Mckinney and/or A Bala	anced Life LLC .
I further understa	nd that if the subscriber's	behavioral health coverage	e is denied or terminated during the
course of treatme	ent, I am completely respon	nsible for all payments of a	any services rendered. This includes
co-payments and	deductibles that are not re	eimbursed through the sub	oscriber's insurance policy. I hereby
authorize <u>J</u>	ane Mckinney and/or A Ba	alanced Life LLC to	
release all inform	ation necessary to secure	the payment of benefits. I	authorize the use of the signature
below on all insur	ance. submissions, wheth	er manually or electronica	lly.
*Client (or guardia	an) printed name:		
*Client (or guardia	an) signature:		Date: