A Balanced Life LLC
creating family wellness

A Balanced Life LLC
New Client Information Form

(For the clinician) Name of clinician: _____

_____ *Please make a copy of the front and back of the client's insurance card and I.d.; and ,attach to this form.*

_____ *Please ask client to complete the billing agreement and credit card authorization form and attach to this form.*

For the client: Please provide the following information and return this completed form to your provider at your first appointment.

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

*Client's Legal Name: _____ Nickname: _____
First MI Last

* Client's Home Address:

_____
Street City State Zip

* 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 Non-Binary

* Client's Marital Status (circle one): Single Married

Other (Other includes Divorced, Widowed & Domestic Partnerships)

* Client's School OR Work Status (circle only one): F/T Student P/T Student OR

Employed Not Employed

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:

_____

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):

_____

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: _____