# 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: ______________