Teel Counseling

Client Information

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| --- | --- |
| **Referred by:** | **Date:** |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client’s Name(s):** | | | | | | | | | | |
| **Parent/:** | | | | | | | | | | |
| **Address:** | | | | **City:** | | | | | **TX, Zip:** | |
| **Phone: Cell:** | | | | **Work:** | | | | |
| **Email:** | | | | | | | | | | |
| May we leave message at: | | | Home: | | | Work: | | Other: | Best time to call: | |
| Gender: Male:  Female: | | | Date of Birth(s): | | | | | | Age(s): | |
| **Presenting Problem(s):** | | | | | | | | | | |
| **Services:** | Individual: | Family: | | | Marital: | | Play Therapy: | | | Group: |
| Best times to schedule: | | | | |  | | | | | |

**If client is minor: Is the child living with:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| a) | Both biological parents | | | | Or single biological parent | | |
| b) | Divorced or remarried parent | | | | | | |
| c) | Legal guardian | | (explain relationship to child) | | | |  |
| d) | Other | (explain relationship to child) | | | |  | |
| Parent/Legal Guardian Name: | | | |  | | | |

***Note:*** If child is living under conditions (b), (c), or (d), Teel Counseling requires a photocopy of the legal document appointing conservator(s). The page(s) specifying conservator(s) along with the signature page is considered sufficient.

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| --- | --- | --- | --- | --- | --- |
| Fee Information Payment must be received at the time of services.  Checks are to be made payable to: **Trey Teel.** Cash andcredit/debit cards are accepted. | | | | | |
| Current gross Household Income | |  | Mo. | Yr. | Fee: |
| *I understand and agree that the above information is correct and true to the best of my knowledge.* | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Insurance | | | |
| Insurance Company: | | ID #: | |
| Policy Holder (if different than above): | | Relation: | DOB: |
| Address of Policy Holder (if different than above): | | | |
| Deductible: | Co-pay: | | |
| Client’s DOB: | | | |
| *(office use only):* Diagnosis Code: | | | |
| Do you require prior authorization from your PCP before treatment? Yes:  No: | | | |
| Is Trey Teel in network? Yes:  No: | | | |
| I understand that whatever insurance does not cover will be billed to me. | | | |
| I understand that billing occurs at the end of each month. | | | |

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| --- | --- |
| **Signature:** | **Date:** |