Teel Counseling

Client Information

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

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| **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 InformationPayment 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.* |

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| 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:** |