FAMILY COUNSELING CENTER
REGISTRATION HISTORY

ABOUT THE CLIENT (ADULT OR CHILD)

Today's Date:_____

Client's Name:_____ **Birthdate**: _____

What name do you want to be called:_____Previous Names _____

___ Male ___Female ____ Non-binary ____ Transgender _____ Intersex ___ Alternate
____ Minor ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed

Street Address: _____

City _____ **State** _____ **Zip** _____ **Phone** #_____

Employer:_____ Work #: _____

Spouse's Name:_____ Spouse's Birthdate: _____

How did you hear about Family Counseling Center?_____

Reason for Visit Today:_____

Previous Counseling?_____When:_____ Where:_____

CHILD INFORMATION (if client is a child)

Child's School:_____ Child's Interests:_____

Name of person living with:_____ Relationship to child:_____

Biological or Adopted Father's Name_____Home Phone #_____

Address:_____ City_____ State _____ Zip _____

Father's Birthdate: _____Father Employed By: _____

Physical Custody _____ Yes _____ No **Legal Custody** _____ Yes _____ No

Biological or Adopted Mother's Name:_____ Home Phone #_____

Address:_____ City_____ State _____ Zip _____

Mother's Birthdate: _____Mother Employed By:_____

Physical Custody _____ Yes _____ No **Legal Custody** _____ Yes _____ No

IN EVENT OF EMERGENCY

Whom should we contact:_____ Relationship to Patient?_____

Home Phone #_____ Work Phone #_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____ Phone#_____

Identification #_____ **Group or Plan** #_____

Primary Insured's Name:_____ **Relationship to Patient**:_____

Primary Insured's Birthdate _____ Insured's Employer _____

PLEASE COMPLETE THE BACKSIDE OF FORM SECONDARY INSURANCE INFORMATION

Insurance Company:_____ Phone#_____
Identification #_____ Group or Plan #_____
Primary Insured's Name:_____ **Relationship to Client**:_____
Primary Insured's Birthdate _____Insured's Employer_____

HEALTH HISTORY

Are you taking any medications?_____ If so, list them:_____
Date of last health care exam?_____ For What Reason?_____
Have you been hospitalized in the last 5 years?_____ If so, for what?_____
This form was completed by: _____

PLEASE READ THE FOLLOWING STATEMENTS AND SIGN AT THE BOTTOM

I have received a copy of the Notice of Privacy Practices.

I give consent to the treatment and assessment of me or my child.

No audio or videotaping of therapy sessions without prior written consent of both the therapist and client.

I authorize Family Counseling Center to leave messages at the number listed on this form and to mail correspondence to the address listed on this form.

RELEASE

I authorize the release of the following information to my insurance company which is necessary to process any claims for a time period not to exceed one year following the termination of service and will include only the following information: **DIAGNOSIS, NUMBER & DATES OF SESSIONS, TREATMENT STRATEGY.**

ASSIGNMENT OF BENEFITS

I hereby authorize Family Counseling Center the medical benefits, if any, otherwise payable to me for the services to be regularly billed by The Family Counseling Center on my account. A Photocopy of this authorization may be honored.

PATIENTS RELEASE & GUARANTEE

I authorize the release of the following information to my insurance company including Medical Assistance, if applicable, which is necessary to process any claims for a time period not to exceed one year following the termination of service and will include only the following information: **DIAGNOSIS, NUMBER & DATES OF SESSIONS, TREATMENT STRATEGY.** I agree that if my insurance company including if applicable Medical Assistance does not pay for the charges incurred or to be incurred, that I will be responsible for the charges.

Date:_____

Signature of Patient or Parent/Guardian (if minor) _____