

Cedar Rapids Counseling & Psychotherapy
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A. CLIENT INFORMATION:

Code: _____
(please leave blank -therapist use only)

Today's Date: _____ **How did you hear about Alexandria?** _____

Client Name: _____
Last First Middle I. Preferred Name

Address: _____
Street/PO Box City State Zip Code

Client Date of Birth: _____ **Age:** _____ **Employer:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

To contact you by phone, please check which of the following would be acceptable:

<input type="checkbox"/> Call home	<input type="checkbox"/> Call work	<input type="checkbox"/> Call cell phone
<input type="checkbox"/> Leave message on machine	<input type="checkbox"/> Leave message on v-mail	<input type="checkbox"/> Leave message on v-mail

B. INSURANCE INFORMATION: If you are covered by one insurance policy, complete part (1) below. If you are covered by two insurance policies, complete parts (1) and (2) below.

(1) **Name of PRIMARY Insurance Company:** _____

Subscriber Name: _____ **DOB:** _____ **Employer:** _____

Policy/ID Number: _____ *(on insurance card)* **Group Number:** _____ *(on insurance card)*

Subscriber Address: *(if subscriber lives at different address from client or parent responsible for billing, please complete)*

Street City State Zip Code

(2) **Name of SECONDARY Insurance Company:** _____

Subscriber Name: _____ **DOB:** _____ **Employer:** _____

Policy/ID Number: _____ *(on insurance card)* **Group Number:** _____ *(on insurance card)*

Subscriber Address: *(if subscriber lives at a different address from client or parent responsible for billing, please complete)*

Street City State Zip Code

C. SPOUSE/SIGNIFICANT OTHER

Name: _____ Phone(s): _____

D. EMERGENCY INFORMATION:

In the event of an emergency, who should be contacted? _____

Relationship to client: _____ Phone(s): _____

Primary Physician: _____ Psychiatrist: _____
Name Name (if applicable)

E. IF CLIENT IS UNDER AGE 18 OR IN COLLEGE:

Mother's Name: _____ Phone(s): _____

Father's Name: _____ Phone(s): _____

Person responsible to pay for services: _____ Relationship to child: _____

Responsible Person's Address: *(if the responsible person lives at a different address from the client, please complete below)*

Street City State Zip Code

GENERAL CONSENT (Please place a checkmark next to Option A OR Option B)

___ A. By signing this form, I am stating that the information I have provided is accurate. I also authorize Alexandria and her staff to release protected health information from my clinical record to any of the following entities as applicable for the purposes of certification of psychotherapy services and/or billing for payment of those services: (1) EAP program, (2) a county funding organization, (3) my health insurance company, and/or its (4) designated managed care company. I understand that this authorization continues as long as I am in therapy with Alexandria, unless I revoke it in writing. However, if I revoke this authorization, I understand that any of the above entities retains the right to information in my clinical record *prior to the revocation date.*

___ B. By signing this form, I am stating that the information I have provided is accurate. I *do not wish* to have an insurance company or other third party pay for the psychological services provided to me or to the person designated as the "client" on the front of this form. I agree to be responsible for payment of all services provided.

Client/Parent/Legal Guardian

Date

