Spence Counseling Center PC
12035 Q Street • Omaha, NE 68137
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OFFICE USE ONLY
Therapist________________ Photo ID _____
Location: OM FR CB RO LW
Info Complete ____ Ins Card____ COF _____
Elig/Ben ______ B/F _______ M/S ______
Scanned ____________ Date ____________

CLIENT INFORMATION

Client Full Legal Name: ____

Address: ____

City: ___________ State: ______ Zip: ____________ Client DOB: __________ Gender: Male ____ Female ____

Client SS#: ________________ Ins. Policyholder SS# __________________ (if different than client)

Single ____ Married ____ Co-habitating ____ Divorced ____ Widowed ____ Minor ____

Home Phone: ____________________ Cell Phone: ______________________ Work Phone: _______________________

Employer: ___________________________ E-mail: ____

Emergency Contact Name & Phone Number: _________________________________ ___________________________

CONTACT INFORMATION

May we contact you by phone and/or leave a message? *(Please check the boxes)* May we **e-mail/text** you and leave a message?

Home: Yes ☐ No ☐ **Cell**: Yes ☐ No ☐ **Work**: Yes ☐ No ☐ **E-mail:** Yes ☐ No ☐ **Text:** Yes ☐ No ☐

Your therapist may use e-mail or text as a means to communicate with clients between sessions. This type of communication will be "business" topics that may include: insurance issues, appointment confirmation or changes, payment arrangements, etc. Therapy sessions will NOT be conducted over e-mail or texting and any communication should not be construed as such unless specific arrangements are made and agreed to in advance and in writing. I further understand and accept the risks associated with unsecured electronic communications.

Consent to Communicate with Primary Care Physician

In order to coordinate care, we may need to contact your primary care physician. I give my consent to any communication with my Primary Care Physician as needed. ☐ I refuse to give consent to send information to my Primary Care Physician.

Name of Doctor _________________________________ Name of Medical Facility _________________________
Address ____ Phone _________________ Fax ___________________
City, State, Zip ___________________________________

IF CLIENT IS A MINOR

If this is a divorce situation, please fill out information below.
Also, provide a copy of the divorce decree, temporary order, and parenting plan.

Child Lives With: Both Parents _____ Mother: _____ Father _____ Other (specify) ____________________

Primary Legal Custody: Both Parents _____ Mother: _____ Father _____ Other (specify) ________________

Primary Physical Custody: Both Parents _____ Mother: _____ Father _____ Other (specify) ______________

Legal Guardian Address *(if different than above)*: Name ______________________ Address: ________________________________

City, State, Zip _______________ Cell/Home/Work Phone: ____ (*circle phone*)

FAMILY INFORMATION

Name	Date of Birth	Gender	Relationship

INSURANCE INFORMATION - **We will need to make a copy of your insurance card and Photo ID**. Thank you.

______________________________ ___________________________ ___________________________
Client or Guardian Signature **Print Name** **Date Signed**

Revised 1/1/2022