Spence Counseling Center PC
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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: _____ Client SS#: _____

City: _____ State: _____ Zip: _____ Client DOB: _____ Gender: Male ____ Female ____

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: _____ Emergency Contact Phone: _____

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 (PCP)

In order to coordinate care, we may need to contact your PCP. I give my consent to any communication with my PCP as needed.

☐ **I refuse to give consent to send information to my Primary Care Physician.**

Name of Doctor & Medical Facility_____
Address _____ City, State, Zip _____
Phone _____ Fax _____

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*)

HOUSEHOLD 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**

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