



*Spence Counseling Center PC*

12035 Q Street • Omaha, NE 68137

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#### OFFICE USE ONLY

Therapist \_\_\_\_\_ Photo ID \_\_\_\_\_  
 Location: OM JC FR CB RO LW BC  
 Info Complete \_\_\_\_\_ Ins Card \_\_\_\_\_ COF \_\_\_\_\_  
 Elig/Ben \_\_\_\_\_ B/F \_\_\_\_\_ M/S \_\_\_\_\_  
 Scanned: \_\_\_\_\_ Date \_\_\_\_\_

### CLIENT INFORMATION

Client Full Legal Name: \_\_\_\_\_ Previous or Maiden Name: \_\_\_\_\_

Address: \_\_\_\_\_ Client SS #: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Client DOB: \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Co-habiting \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Minor \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ E-mail: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

**Ethnicity:** Hispanic/Latino \_\_\_\_\_ Non-Hispanic/Non-Latino \_\_\_\_\_ Prefer not to answer: \_\_\_\_\_

**Race:** \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Other \_\_\_\_\_ Choose Not to Disclose \_\_\_\_\_

### HOW WE MAY CONTACT YOU

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

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

Your therapist may use e-mail or text 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.

To Opt Out at any time, reply **STOP** to any text message. For help, reply **HELP** to any text message. See SMS Terms and Conditions Policy at [www.spencecounselingcenter.com](http://www.spencecounselingcenter.com).

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**Enroll in Patient Portal – For Dr. Sena's Patients ONLY:** Yes \_\_\_\_\_ No \_\_\_\_\_  
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### Consent to Communicate with Primary Care Physician (PCP)

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 the 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 Name: \_\_\_\_\_ Cell/Home/Work Phone (*circle phone*): \_\_\_\_\_

Address (*if different than above*): \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**(Continue to the next page and sign the document)**

**INSURANCE INFORMATION**

***We will need to make a copy of your Insurance Card and Photo ID.***

***\*\*\* Failure to provide this information could result in full cash rates for services rendered.\*\*\****

**Primary Insurance**

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policyholder Legal Name: \_\_\_\_\_ Policyholder SS# \_\_\_\_\_  
Policyholder DOB: \_\_\_\_\_ Policyholder Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

**Secondary Insurance**

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policyholder Legal Name: \_\_\_\_\_ Policyholder SS# \_\_\_\_\_  
Policyholder DOB: \_\_\_\_\_ Policyholder Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

\_\_\_\_\_  
**Client Name**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Client or Guardian Signature**

\_\_\_\_\_  
**Print Name (if different than client)**

\_\_\_\_\_  
**Date Signed**