Mountain View Therapy

CLIENT RECORD FORM

(Please Print)

Today's date:

CLIENT INFORMATION

Client's last name: First: Middle: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F

Street address, City, State, Zip Code:

Phone Numbers:
Home ( )
Cell ( )
Work ( )

Okay to leave messages at:
Home Phone ❑ Yes ❑ No
Cell Phone ❑ Yes ❑ No
Work Phone ❑ Yes ❑ No

Occupation: | Employer: | Email Address:

Relevant Medical Conditions:

Medications:

Primary Care Physician: (Name, Address, Phone Number)

Psychiatrist: (Name, Address, Phone Number)

Reason for seeking counseling:

INSURANCE INFORMATION

Is the client covered by insurance? ❑ Yes ❑ No

Name of primary insurance:

Subscriber's name: | Subscriber's Employer: | Birth date: / / | Group no.: | ID no.: | Co-payment: $

Client's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | ID no.:

Client's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of Emergency Contact | Relationship to Client: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize Mountain View Therapy or insurance company to release any information required to process my claims.

Client/Guardian signature *Date*