

Counseling Associates for Well-Being
Data Sheet

Name: _____ Email _____

Name you prefer to be called: _____ Social Security # _____ Date of Birth: _____
Race _____ Gender _____

Marital Status _____ Spouse/Partner name _____ Spiritual Preference _____

Address: _____ City _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell/other: _____

May we leave a message at Home _____ Work _____ Cell/other _____? What is the best time to reach you? _____

Would you like an appointment reminder by text or email? _____ If so at what number or email? _____

Emergency Contact Name: _____ Phone _____ Relationship to you _____

Referred by: _____ May we contact them to thank them for the referral? _____

If you were not referred, how did you find out about us? Facebook, Google, Psychology Today, Radio ad, Friend or family,
Other: _____

Occupation: _____ Place of Work: _____ full-time student? _____

Number of hours per week that you work: _____ Highest education level: _____

Briefly describe the main reason that you are here for care: _____

Insurance Information:

Name of insured if different than client _____ Employer _____

Insured's SSN _____ Insured's DOB _____ Relationship to client _____

Insured's Address _____

Insurance Company _____ Plan name _____ Member ID# _____ Group# _____

Phone # (on back of card) _____ Claims address _____

Have you called for authorization and to confirm mental health benefits as well as information regarding co-pays or deductible? _____ Please supply all information from confirmation call below.

(As stated in our Professional disclosure, it is your responsibility to call regarding authorization and benefits. You will be charged full session fees until coverage is confirmed.)

Policy effective date _____ Ded. Amount for ind. _____ fam _____ Combined w/
medical? _____

Amount met _____ Policy covers LCSW? _____ Therapist in network? _____ Out of network benefits? _____

Number of visits allowed annually? _____ Copay _____ Authorization needed? _____ If so, authorization code? _____

Authorization units _____ CPT code _____ CPT code _____ Date range authorization: from _____ to _____

Referral needed? ___ **Do you have any Medicare Benefits?** _____

****For office use only*****

Diagnosis _____ Chart Name _____

_____ Therapist _____ Entered in Delphi Y N