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_ ˉ _____Cell/other ˉ ? What is the best time to reach you?_______________

Would you like an appointment reminder by text or email? ˉ 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? ˉ
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? ˉ Therapist in network? ˉ Out of network benefits? ˉ ___

Number of visits allowed annually?_______Copay________Authorization needed? ˉ If so,authorization code?_______________

Authorization units________CPT code_______CPT code______Date range authorization: from ______to_______

Referral needed? ˉ **Do you have any Medicare Benefits?** ˉ
******For office use only***
Diagnosis_______._______ ____________________Chart Name______________________________________
_______._______ ____________________Therapist__________________Entered in Delphi Y N