HEALTHY SYNERGY
psychological services

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Client Information

Instructions: Please fill out this form as completely as possible and please print legibly. If you have questions or concerns about any items, please discuss them directly with your therapist.

Basic Information

Today's Date: _____

Client's name: _____

Age: _____ DOB: _____

Address: _____

_____

Phone Numbers: May we leave a message?

Cell Phone: _____ Voicemail: _____ Text: _____

Home Phone: _____ Yes: _____ No: _____

Work Phone: _____ Yes: _____ No: _____

Email Address: _____ Yes: _____ No: _____

How did you learn about our practice? _____

Information for Adult Client

Occupation: _____ Employer: _____

Single: _____ Married: _____ (# years ____) Partnered (# years ____)

Separated: _____ Divorced: _____ Widowed: _____

Names and Ages of Children: _____

_____

Previous Mental Health Care: Yes _____ No: _____

If yes, Provider's Name: _____ Date of Treatment: _____

Information Needed For Child Client

Child's School: _____ Grade: _____

Teacher: _____

Contact Information for Parents or Primary Guardians:

Name: _____ Relationship: _____

Home Address: _____

_____

Phone Numbers: May we leave a message?

Cell Phone: _____ Voicemail: _____ Text: _____

Home Phone: _____ Yes: _____ No: _____

Work Phone: _____ Yes: _____ No: _____

Email Address: _____ Yes: _____ No: _____

Additional Parent/Guardian/Information if Applicable:

Name: _____ Relationship: _____

Home Address: _____

_____

Phone Numbers: May we leave a message?

Cell Phone: _____ Yes: _____ No: _____

Home Phone: _____ Yes: _____ No: _____

Work Phone: _____ Yes: _____ No: _____

Email Address: _____ Yes: _____ No: _____

Marital Status of Parents: Married: ____ Partnered: ____ Separated: ____

Divorced: ____

If Applicable Step-Parent Name(s): _____

Sibling's Name: _____ Age: _____

Sibling's Name: _____ Age: _____

Sibling's Name: _____ Age: _____

Sibling's Name: _____ Age: _____

Sibling's Name: _____ Age: _____

Primary Insurance Information

Insurance Company: _____

Member ID#: _____ Group/Plan #: _____

Insurance Phone #: _____

Are you the policy holder? Yes ___ No ___ If no, please complete the following:

Policy Holder's Name: _____

Phone #: _____

DOB: _____ Relationship to Policy Holder: _____

Employer: _____

Secondary Insurance Information

Insurance Company: _____

Member ID#: _____ Group/Plan #: _____

Insurance Phone #: _____

Are you the policy holder? Yes ___ No ___ If no, please complete the following:

Policy Holder's Name: _____

Phone #: _____

DOB: _____ Relationship to Policy Holder: _____

Employer: _____

Insurance Disclaimer

Some clients make a choice to not utilize the mental health benefits associated with their insurance because they prefer to maintain their privacy and/or control the direction of their care. When you utilize your health insurance benefits your insurance company will require that we provide them with a mental health diagnosis. Additionally, the insurance company may require access to your record to verify an accurate diagnosis and need for care. The insurance company may also dictate your treatment plan, type of therapy provided, and session limits. You may choose not to use your health insurance benefits whether they are in-network or out-of-network benefits.

Please sign below if you are choosing not to use your health care benefits (in-network or out-of-network) and are making the choice to pay directly for the services you receive at Healthy Synergy Psychological Services, LLC.

_____ _____
Signature Date

Signature

All Clients/Parents/Guardians Sign Here:

I certify that all the information I have provided above is accurate to the best of my knowledge.

_____ _____
Client/Parent/Guardian Signature Date

Clients Using Insurance Benefits Please Sign Both Places Below:

I understand that certain information may be required by third party sources for the purpose of treatment, payment (including collections of past due accounts) and health care operations. I hereby consent to Healthy Synergy Psychological Services, LLC, releasing my health information for the purposes of treatment, payment, and healthcare operations. I hereby assign to the practice all benefits/payments from my insurance carrier for services rendered to my dependents and/or myself. I understand that I am responsible for all amounts not covered by my insurance.

_____ _____
Signature Date