PAMELA BASS COUNSELING SERVICES, PC

Client Information

Name_____Birthday_____ Sex M F

Address_____City_____ State____Zip_____

Home Phone_____ Cell_____**Soc. Sec. Number**_____

Preferred method of contact: (Please initial): ____phone ____email ____text

Permission to contact & leave a message at: (yes or no) _____home ____work _____cell

INSURANCE INFORMATION:

INSURED'S NAME_____BIRTHDAY_____

Employed by_____ Phone_____ # of years _____

Insurance Co._____ Insured Name & DOB_____ ID #_____

Secondary insurance co? YES NO **Authorization #** _____ # of Ses_____

Spouse _____ How many children_____ # living with you? _____

1st Child/age_____ 2nd_____ 3rd _____ 4th_____

Emergency Name & Phone: _____ Relationship: _____

Name of Doctor: _____ Phone _____

Address: _____ Date of Last Physical: _____

I AUTHORIZE PAMELA BASS COUNSELING SERVICES, PC TO RELEASE THE INFORMATION NECESSARY TO PROCESS THE INSURANCE CLAIMS. I VERIFY THAT ALL INFORMATION IS ACCURATE AND I AGREE TO BE FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES PROVIDED.

_____ _____

SIGNATURE OF CLIENT/GUARDIAN **DATE**

(IF GUARDIAN): RELATIONSHIP TO CLIENT: _____

Please initial one:

I HAVE BEEN OFFERED PAMELA BASS COUNSELING SERVICES PC PRIVACY NOTICE &

_____ **I HAVE DECLINED** OR _____ **I HAVE RECEIVED** NOTICE.

_____ _____

SIGNATURE OF CLIENT/GUARDIAN **DATE**

(IF GUARDIAN) RELATIONSHIP TO CLIENT: _____