CLARISSA I. PEARCE, LMHC 360.393.9015

PLEASE COMPLETE AND BRING TO FIRST APPOINTMENT

CONTACT INFORMATION

Name: _____ Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ ☐ OK to leave message ☐ OK to text?

Home Phone: _____ ☐ OK to leave message

Email: _____ ☐ OK to email

Occupation: _____

Date of Birth: _____ Age: _____

Emergency Contact: _____ Phone: _____

Relationship to you: _____

COMPLETE THIS SECTION IF YOU ARE USING INSURANCE

PRIMARY INSURANCE (Info found on card)

Insurance Company: _____ Phone: _____

Subscriber's Name: _____ Subscriber's Birthdate: _____

Subscriber's Relationship to Client: Self _____

ID# _____ Group/Plan # _____

SECONDARY INSURANCE (Info found on card)

Insurance Company: _____ Phone: _____

Subscriber's Name: _____ Subscriber's Date Birthdate: _____

Subscriber's Relationship to Client: Self _____

ID# _____ Group/Plan # _____

HEALTH INFORMATION

Current or past health problems: _____

Have you ever been hospitalized for psychological reasons? ☐ NO ☐ YES _____

Have you ever attempted suicide? ☐ NO ☐ YES _____

Have you had serious thoughts of ending your life recently? ☐ NO ☐ YES _____

Have you ever intentionally injured yourself? ☐ NO ☐ YES _____

Are you currently taking medication (include birth control)? ☐ NO ☐ YES _____

Medication: _____ Date Started: _____

Medication: _____ Date Started: _____

Name of Prescriber: _____ Last Visit: _____

WHAT ARE THE MAIN CONCERNS THAT BRING YOU TO COUNSELING?

_____

_____

_____

_____

AGREEMENT AND CONSENT FOR SERVICES

By signing below, I attest that I have read, understood, and agreed to the Office Policies and Disclosure Statement. I understand that it is my responsibility to reimburse my therapist for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered or I do not have insurance coverage at this time, I agree to pay any and all costs of counseling. Costs may include any missed appointments, fees for written reports, phone calls on my behalf, or any other costs of providing services on my behalf.

x_____ _____

Client's Signature Date

IF USING YOUR INSURANCE TO PAY FOR SERVICES, SIGN THIS SECTION

I authorize the release of any medical or other information necessary to process this claim through any insurance company. I authorize payment to Clarissa I. Pearce, LMHC, LLC for services rendered as stated on claims submitted to my insurance company. I also understand that it is my responsibility pay for any services provided on my behalf. In the event that my insurance does not cover costs for services rendered, I agree to pay any and all costs of counseling or services provided on my behalf.

x_____ _____

Client's Signature Date

x_____ _____

Parent's Signature Date

PRINT NAME: _____