Client Information Form

Last Name: _____First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Transgender/Gender Non-Conforming

Marital Status: ☐Single ☐Married ☐Divorced ☐Cohabitating Spouse/Partner Name: _____

Emergency Contact/Next of Kin: _____ Phone: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Referred By: _____

INSURANCE INFORMATION (N/A for Capital EAP)

Primary Insurance: _____ ID No.: _____
Subscriber's Name: _____Group No: _____
Subscriber's Date of Birth: _____ Subscriber's Employer: _____

Secondary Insurance: _____ ID No.: _____
Subscriber's Name: _____Group No: _____
Subscriber's Date of Birth: _____ Subscriber's Employer: _____

ACKNOWLEDGEMENT OF RECEIPT OF TERMS OF SERVICE AND CLIENT STATEMENT OF UNDERSTANDING: I have read and understand the Client Statement of Understanding and Terms of Service. I agree to the terms of payment and understand the scope of services provided by Capital Counseling and the program I am utilizing.

INITIALS: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I understand that Capital Counseling, Notice of Privacy Practices describes the types and uses of disclosure of my protected health information that may occur in my treatment, payment of my bills or in the performance of the behavioral health operations Capital Counseling. By placing my initials in this section, I acknowledge that a copy of Capital Counseling Notice of Privacy Practices brochure has been provided to me.

INITIALS: _____

Client Signature: _____ Date: _____