



Please fill out this form carefully and completely

Client Information

Date of Birth 1. _____ Age ____ Sex: M F Gender: M F Non-Binary Other

Date of Birth 2. _____ Age ____ Sex: M F Gender: M F Non-Binary Other

Preferred Pronouns: _____

Name(s) 1. _____

Name(s) 2. _____

First

Initial

Last

Contact Details

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: 1. _____ Cell Phone: _____

Fax: _____ E-mail: _____

Employer Information

Employer: _____

Company

Occupation/Title

Address

City

State

Zip

Background & Health

Marital Status: Single Engaged Married Separated Divorced Widow(er)

Denomination or Religious preference: _____

Personal Physician or Group Practice: _____

Current Medications: _____ Any allergies: _____

In an emergency, please notify: _____

Phone: _____

Race: _____

Education-Highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14

Whom can we thank for your referral? (choose one)

Previous counselor or therapist: _____ When: _____ Number of Sessions: _____

Telephone Book Yellow Pages Newspaper Minister Friend Co-Worker

Physician Attorney Client Newsletter Radio TV Brochure Website

Counselor: _____ Appointment Day & Time: _____

Insurance Coverage

If you intend to use your health insurance coverage, please call the mental health provider listed on your insurance card to obtain prior authorization. You will also need to confirm that your therapist and the Counseling Center at Charlotte is a provider for your specific plan.

If you wish, the CCC will file insurance claims as a courtesy.
A photocopy of your card will be necessary.

The **standard fee of \$165** must be charged when filing with all insurance companies.
The **initial session fee is \$200**.

If you decide to pay out-of-pocket for sessions, those sessions will not be filed later to your insurance company by CCC.

Please check your preference below: (check one)

I plan to use my insurance benefits _____

I plan to pay out-of-pocket _____

Statement of Understanding

I authorize the release of any medical information necessary to process insurance claims filed on my behalf. I hereby assign payment of insurance benefits to CCC. I acknowledge that I am financially responsible for the payment for services whether or not my health insurance covers services.

I have read and understand the center's policy on charges, insurance billing, 24-hour cancellations and missed appointments. I agree and accept financial responsibility for services rendered.

I have read my counselor's professional disclosure statement and asked questions, if needed. I have been informed about how my privacy and confidentiality will be maintained by the Center (HIPPA statement). A copy of such is available if desired. Please ask your therapist.

Signature: _____ Date: _____