Dear Prospective Client,

Welcome to Gahanna Counseling, LLC! Please consider filling out this paperwork prior to your appointment date so you may thoroughly read it and ask any questions you may have. We recommend contacting your insurance company prior to your initial appointment so you are familiar with your benefit as well as any copay or deductible you may have.

1) Prior to your first visit, you must insure you have all information listed on the Insurance Information Form. While this information is generally on your insurance card, you can always call the insurance company if you are having trouble with an item.
2) Some Employee Assistance Programs require an authorization number. This is needed in order to cover your services here at our office. If authorization is not obtained before your initial appointment, your service may be denied, and you will be charged the therapist's full fee.

We look forward to working with you!

Client Information Sheet

Please make sure that all information is complete before your session begins. If we do not have this information, we can not bill your insurance company.

Client Name: _____

Street Address:_____

City: _____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

DOB: _____ Age: _____ Gender: ☐ Male ☐ Female

Social Security #: _____

Employer/school: _____

Occupation/Grade: _____

Employer/school phone: _____

Marital Status (of client): □Never Married □Domestic Partnership □Married
□Separated □Divorced □Widowed

Spouse's Name: _____

Emergency contact

*Parent(s)/Guardian(s) (if client is a minor):

Name: _____

Address: _____

Home phone: _____Cell phone: _____

Relationship to client: _____

Employer: _____

Employer phone: _____

Responsible Party Information

If the client is not financially responsible for payment of services, please complete the following information concerning the responsible party.

Responsible Party Name: _____

Street Address: _____

Social Security Number: _____ DOB: _____

Relationship to Client: □ Parent/Guardian □ Spouse □ Other_____

Home Phone: _____ Work phone: _____

Cell phone: _____

If we need to contact you:

Message can be left at (check all that apply):

☐ Home voice mail/answering machine

☐ Cell phone voice mail

☐ Work voice mail

☐ E-mail (please provide) _____

*Please note: Email correspondence is not considered to be a confidential medium of communication

Can we send you an email to remind you of future appointments? ☐ Yes ☐ No

Who Referred You To This Office?

☐ Doctor ☐ Agency ☐ School ☐ Google ☐ Psychology Today

☐ Friend/Family ☐ Other_____

Primary Care Physician

Name: _____

Physician Address: _____

Physician Phone: _____

Primary Insurance Information

Primary Insurance Company Name: _____

Identification Number on Card: _____

Group Number (if applicable): _____

Subscriber's Name: _____

(The person who holds the policy)

Subscriber's Social Security Number: _____

Subscriber's Address: _____

Subscriber's Phone: _____

Client's Relationship to Subscriber: _____

Subscriber's DOB: _____

Subscriber's Employer: _____

Subscriber's Work Phone: _____

Authorization Number: _____

Please remember, we DO NOT bill secondary insurance. You may bill this on your own.

What may we help you with? _____

How long has this problem persisted? _____

Have you previously been involved in counseling for any reason?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently seeing a psychiatrist?

□ No □ Yes, please name: _____

Have you ever been psychiatrically hospitalized?

□ No □ Yes

1. Date of Hospitalization: _____ Number of days_____

   Hospital name: _____

   Chief Reason: _____

2. Date of Hospitalization: _____ Number of days _____

Hospital name: _____

Chief Reason: _____

Are you currently taking any medications (for psychiatric or other reasons)?
□ No □ Yes, please list:
Medication Names, Daily Dosage, and Purpose:

_____

_____

_____

_____