

Potomac Crossroads Counseling, LLC

Client Data Form

(Please Print)

Today's date:	Primary Care Physician:
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PATIENT INFORMATION

Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		City:	State/Zip:		
Mailing address: (if different)		City:	State/Zip:		
Social Security no.:	Home Phone:	Cell Phone:			
	()	()			
Occupation:	Employer:	Employer phone no.:			()

How did you hear about our office? (check all that apply)

<input type="checkbox"/> Primary Care Physician	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other
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Please list any medications that you are taking:

INSURANCE INFORMATION

Subscriber's name:	Subscriber's social security no.:	Subscriber's Birth date:
Address (if different from patient's):		Home phone no.:
		Cell Phone:
		()
Is insured person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this patient covered by insurance?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:	Employer address:	Employer phone no.:
		()
Name of Primary Insurance:	Patient's relationship to subscriber:	
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
ID/member no.:	Group no.:	Co-payment: \$
Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:
		Group no.:
Patient's relationship to subscriber:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		()	()

The above information is true to the best of my knowledge. I understand that I am required to give 24-hour notice in case of cancellation(s) or that time will be charged to my account. I, the undersigned certify that I have insurance coverage as noted and assign directly to Potomac Crossroads Counseling, LLC all insurance benefits, if any, otherwise payable to me for the services rendered. **I understand that I am responsible for any and all charges whether or not paid by insurance.** I agree that if this account goes to collection, I am responsible for all legal/collection costs. I hereby authorize Potomac Crossroads Counseling, LLC to release all *Protected Health Information* necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Client Signature:	Date
I, hereby give consent for the treatment of my minor child: (child's name) _____ by Potomac Crossroads Counseling, LLC	Date
Parent/Guardian signature:	