Samaritan Counseling Center, INC.
dba The CENTER, a Samaritan Counseling Center
CLIENT/PATIENT INFORMATION

The following information is required to properly file Insurance/Funding forms for payment consideration under new Healthcare Reform and Reporting laws. Failure to provide the following information may result in non-payment of your claims. If this occurs, you will be responsible for payment in full. Please fill in all blanks as completely as possible and circle any multiple choice options.

If patient/client is a child or has a guardian, the parent or guardian should fill in the information below for the patient. If you are the patient and the guarantor, fill out both sections.

Today's Date: _____

Patient Information:

Patient First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip+4:** _____

Social Security Number: _____ **Date of Birth:** _____

Marital Status: Single _____Married _____ Separated _____Divorced _____ Widowed _____ Domestic Partner _____

Gender: Male Female Transgender Gender Fluid Other _____

Primary Race: White Black or African American American Indian or Alaskan Native Asian

Native Hawaiian or Other Pacific Islander Other (Specify) _____

Secondary Race: White Black or African American American Indian or Alaskan Native Asian

Native Hawaiian or Other Pacific Islander Other (Specify)_____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Student Status: Full Time ____Part Time ____ Non-Student _____ **Preferred Language:** _____

Present Problem: _____

Previous or Current Treatment: Yes No **If yes:** Inpatient Outpatient Duration/Dates_____

Name of hospital, clinic, or therapist where treated: _____

May we contact your previous or current therapist? Yes No Phone Number:_____

Reason for treatment: _____

_____

Who referred you to The Center: _____

Primary Care Physician: _____ **Phone:** _____

May we contact your Primary Care Physician? Yes No

Have you served on active duty in the U.S. Armed Forces, military Reserves, or National Guard? Yes No

What is your religious affiliation, if any: _____

How does your religious affiliation affect your life: _____

Guarantor Information:

Guardian First Name: _____Middle Initial: _____ Last Name: _____
(If different from patient or above information)

Address: _____
(If different from patient or above information)

City: _____ State: _____ Zip+4: _____

E-Mail:_____ Preferred Language: _____

Social Security Number: _____ Date of Birth: _____
(If different from patient or above information) (If different from patient or above information)

Driver's License/Picture ID: _____State Issued: _____

Employment Status: Full Time _____ Part Time _____ Not Employed _____ Disabled _____ Retired _____

Employer: _____

Employers Phone Number: _____ Ext: _____

The below person is the emergency contact individual for the patient and can also be allowed to make or verify your appointments and/or communicate with the office about your billing account.

Emergency Contact Name: _____ Relationship: _____

Daytime Phone: _____Evening Phone: _____

Contact Name: _____ Relationship _____

Daytime Phone: _____Evening Phone _____

Insurance:

Payer Name: _____ Policy Type: _____

Address: _____ Member #:_____

City/ State/ Zip: _____

Phone #:_____

Policy Holder:

Name: _____ Relationship to Client: _____

Address: _____ SS #: _____

City/ State/ Zip: _____ Date of Birth: _____

Phone #: _____

I acknowledge the above information to be true and accurate to the best of my knowledge.

_____ _____
Signature of Patient/Guardian **Date**

_____ _____
Printed Name of Patient/Guardian **Relationship to Client**

_____
Witness if Client Unable to sign