



Counselor's Name \_\_\_\_\_

CLIENT INFORMATION FORM – PLEASE PRINT

Name of Client: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male Female Primary Language: \_\_\_\_\_

Single Married Separated Divorced Widowed Child

Referral Source: Previous Client Physician Pastor Advertising

Other (please specify) \_\_\_\_\_

Email Address: \_\_\_\_\_

Briefly state the nature of the presenting problem: \_\_\_\_\_

\_\_\_\_\_

*For purposes of coordination of care, please answer the following:*

Name of primary care physician: \_\_\_\_\_

Names of other regularly treating physicians (psychiatrist, counselors, etc.): \_\_\_\_\_

\_\_\_\_\_

May we have permission to contact them? Yes No

*“That all may have life, life in all its fullness.” – John 10:10*

[lifecoachingandcounseling.net](http://lifecoachingandcounseling.net)

## INFORMED CONSENT FOR COUNSELING and/or COACHING

I give my authorization and consent to receive counseling and/or coaching services at LIFE Coaching & Counseling Centers.

I understand that my right to confidentiality is limited by: 1) Any threat to hurt myself (suicide) or others; 2) A suspicion by my counselor or coach of abuse toward anyone, especially if the client is a minor child or an adult over the age of 65.

I have been informed that my counselor or coach may consult with another counselor or coach at LIFE Coaching & Counseling Centers for the purpose of maximizing my counseling or coaching while maintaining my confidentiality.

I am aware that my counselor's or coach's value system is the result of his or her Christian faith, and I am freely entering into the counseling or coaching relationship with that knowledge.

I am freely choosing to enter counseling and/or coaching, and I understand that I may discontinue these services at any time.

I understand my counseling/coaching fee is \$\_\_\_\_\_ per 45-55 minute session and that extended sessions will incur additional charges pro-rated at the same rate. If I need telephone counseling between sessions (beyond a brief call of 5 minutes), I understand I will be charged at the same rate, pro-rated, according to the time needed.

I understand that my checks for counseling fees need to be made out to James Fry, Jim Fry, or LIFE C&C and that he will submit claims to my insurance company for payment.

I am aware that I will be charged a fee of \$50 for any missed session with less than a 24 hour notice, except in the case of an emergency.

REQUIRED: I authorize charges to my credit card for missed appointment fees, telephone counseling, unpaid counseling fees, and fees for cancellation with less than 24 hours' notice. All credit card charges will include a 5% processing fee.

VISA/Mastercard # \_\_\_\_\_

Name on Card \_\_\_\_\_

Expiration Date \_\_\_\_\_ 3 numbers on back \_\_\_\_\_

Street Number where Credit Card Statement is sent \_\_\_\_\_ & Zip Code \_\_\_\_\_

\_\_\_\_\_  
Client or Guardian

\_\_\_\_\_  
Date

## BILLING INFORMATION and ADDITIONAL CHARGES

What will be your means of payment? Insurance\_\_\_\_\_ Self-Pay\_\_\_\_\_  
For self-pay, complete Section A. For Insurance, complete section B.

### SECTION A

What is the combined yearly income for your household?

- \_\_\_ under \$25,000
- \_\_\_ \$25,000 - \$35,000
- \_\_\_ \$35,000 - \$45,000
- \_\_\_ \$45,000 - \$55,000
- \_\_\_ \$55,000 - \$65,000
- \_\_\_ \$65,000 - \$75,000
- \_\_\_ \$75,000 - \$85,000
- \_\_\_ \$85,000 - \$95,000
- \_\_\_ \$95,000 - \$105,000
- \_\_\_ \$105,000 - \$115,000
- \_\_\_ \$115,000 - \$125,000
- \_\_\_ over \$125,000

Our fees are on a sliding scale basis, which is determined on the basis of your total household income. A fee of \_\_\_\_\_ has been mutually agreed upon based on the above information. I agree to notify my therapist in the event my financial situation changes. I also agree that I will pay this fee by cash, check, or credit card at each session. I understand that all credit card charges will include a 5% processing fee. If I so request, a receipt will be given to me for tax purposes.

If I need to receive counseling by telephone between sessions, I agree to pay for the portion of a session used. I will give my counselor-therapist at least 24-hour notice of my need to cancel an appointment unless an emergency is involved, or I will pay a \$50.00 charge for the missed appointment.

If I need to have any written reports to insurance companies, courts, attorneys, etc., I agree to pay for the time involved in the creation and delivery of the document(s) at the rate of \$125 per hour. If I need the counselor to attend and/or testify at a court case, I agree to pay \$125 per hour for travel time to and from the court, waiting time, and testifying time.

\_\_\_\_\_  
Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor/Therapist/Coach

\_\_\_\_\_  
Date

## SECTION B

Please complete the following with the information of the Primary Insured Person  
(also called the Subscriber or Policy Holder):

Name of the Primary Insured Person who owns the Insurance \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Address (if different from client) \_\_\_\_\_  
\_\_\_\_\_

Policy Holder's Contact Phone Numbers: Cell \_\_\_\_\_ Home \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Job Title \_\_\_\_\_

Health Insurance Company Name \_\_\_\_\_

Contract/ID/Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Social Security Number \_\_\_\_\_

Any Additional Health Insurance Carrier? If so, please specify:  
\_\_\_\_\_

Co-pay and co-insurance amounts are determined by your individual insurance plan. It is the responsibility of LIFE Coaching and Counseling associates to charge these amounts. The co-pay/co-insurance amount determined by your plan is \_\_\_\_\_ per session.

Yearly deductible amounts as determined by your plan must also be met before insurance will pay and are the responsibility of the client.

Unmet deductible on your plan is \_\_\_\_\_.

This will be paid incrementally at \_\_\_\_\_ per session.

Receipts for amounts paid are available upon request.

By signing below, I agree to pay all co-pays, co-insurance, and/or deductible amounts at each session as indicated above. I hereby authorize the release of information necessary to file claims, obtain pre-certification of benefits, or verify limits of coverage by my insurance company. I also agree to assign all insurance benefits to the provider of services and agree to pay the difference between the insurance benefits payment and the total charges. I further agree that if my eligibility for coverage by my insurance company cannot be confirmed at this time, or if I or any member of my family is not eligible for coverage, or my coverage has expired at the time services have been rendered, I hereby take full financial responsibility for payment for any and all services rendered to me or any member of my family. A copy of this signature is as valid as the original.

I have read, understand, and agree to all of the above.

\_\_\_\_\_  
Insured, Client, or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness/Counselor

\_\_\_\_\_  
Date