ADVANCED COUNSELING
& THERAPY SERVICES, L.L.C.

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Grand Rapids, MI 49546
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advancedcounselingandtherapyservices.com

Therapist:
Date of apt:

# PATIENT INFORMATION

Client Name ______________________ Birthdate __________

Address ______________________ City __________ State _____ Zip __________

Home Phone# __________ Work# __________ Cell# __________

Email __________ Marital Status __________

Children __________ Age __________

Children __________ Age __________

Medications ______________________

Primary Care Physician ______________________

Emergency Contact ______________________ Phone# __________

Relationship to Patient ______________________

## Responsible Party if Different from Above

Name ______________________ Address ______________________

Home Phone# __________ Work# __________ Cell# __________

## Insurance Information

**Primary Carrier** __________ Subscriber's Name __________

Subscriber's Address __________ DOB __________

Subscriber's ID# __________ Employer __________

Group # __________ Subscriber's Name __________

**Secondary Carrier** __________ DOB __________

Subscriber's ID# and Group # ______________________

**Please Read Carefully**

AUTHORIZATION FOR RELEASE OF INFORMATION FOR BILLING PURPOSES

I hereby authorize the release of information necessary for third-party claim submission and/or payment services. I authorize payment of third party benefits to Advanced Counseling & Therapy for therapy services provided. I understand that I am responsible to pay Advanced Counseling & Therapy for all sessions rendered. Additionally, I understand I am responsible to pay a fee for any no show or late cancellation, less than 24 hours prior to your scheduled appointment.

**Signature:** ______________________ **Date** __________