North Star
COUNSELING SERVICES, LLC

CLIENT INFORMATION AND INSURANCE FORM

CONFIDENTIAL

Therapist_____
Diagnosis_____

Date: _____ Who referred you to NCS? _____

Client name: _____

Address: _____ City: _____

State:_____ Zip: _____ Home phone: _____

Marital status: _____ Sex: ____ Birth date: _____ Age: _____

Employer name/address: _____ Work phone: _____

Is this a worker's comp claim? _____ If so, list the date of the injury _____

Emergency contact name: _____ Emergency phone #: _____

If person financially responsible is yourself, write "self" on the next line and go to the next section

Person financially responsible: _____ Relationship to client: _____

Address: _____ City: _____

State: _____ Zip: _____ Home phone : _____

DEPENDENT CHILDREN

Name/birth date	Name/birth date
_____	_____
_____	_____
_____	_____

Primary care physician's name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

(over)

PATIENT ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I acknowledge that I have received the informed consent for treatment form. I hereby agree to treatment and understand that should I have questions I will contact Dr. Shook-Woolley.

I herby authorize any insurance carrier to make payment directly to North Star Counseling Services, LLC (NCS) of any benefits otherwise payable to me for services provided by Dr. Shook-Woolley. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I further authorize NCS to release to my insurance company(ies) any information from my record which may be necessary to determine benefits payable under my policy. This information may include, but is not limited to diagnosis, treatment procedure and/or photocopies of all or part of my record.

_____

Patient signature

_____

Witness signature (if patient is a minor or is incompetent)

_____

Date