

**John Hawkins, LPC, NCC
Professional Counseling Services**

CLIENT DATA FORM

NAME: _____

ADDRESS: _____

PHONE: _____ **E-MAIL:** _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

BUSINESS PHONE: _____

NAME OF SPOUSE OR PARENT: _____

SPOUSE OR PARENT PHONE: _____

SPOUSE/PARENT ADDRESS (if different from above): _____

* * * * *

Who referred you to me? _____

What do you hope to gain from counseling? _____

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CLIENT INSURANCE INFORMATION

(NOTE: We generally do not file insurance for office visits. Office Visits are paid at the time of service, either by check or cash. We do not take charge cards or debit cards. We also do not take Medicaid or Medicare.)

INSURANCE COMPANY 1

Name: _____

Address: _____

Phone: _____

Policy Holder: _____

Insurance Number: _____

Group Number: _____

INSURANCE COMPANY 2

Name: _____

Address: _____

Phone: _____

Policy Holder: _____

Insurance Number: _____

Group Number: _____

RELEASE OF INFORMATION:

I hereby authorize John Hawkins, LPC to release to insurance company any information to process my claim.

Client Signature (Parent Signature if under 18) _____ **Date** _____