CHRISTIAN LIFE COUNSELING

CONFIDENTIAL INFORMATION

Today's date _____

Client's Name _____Date of Birth _____

Address _____City _____ Zip Code _____

Home Phone No. _____ Office Phone No. _____ Cell Phone No. _____

E-mail Address _____ Sex F/ M Single Married Widowed Divorced If student: Full-time Part-time

If Patient Is A Minor

Father's Name _____ Date of Birth _____ Home Address _____

Mother's Name _____ Date of Birth _____ Home Address _____

Name of Responsible Party _____ Relationship to Patient _____

Address _____ Home Phone No. _____ Work Phone No. _____

Cell Phone No. _____ Driver's License No. _____

Spiritual

Church Affiliation _____ Pastor 's Name _____

Has there been a point in your life in which you have accepted Jesus Christ as your Lord and Savior? YES NO. If NO, are you interested in discussing this during session? _____

Do you find your faith (Please circle response): Satisfying Challenging Joyful Meaningless Dull Other:_____

Previous Counseling/Interventions

Provider's Name _____ Address/phone number _____

Approximate Dates _____ Outcome:_____

Referred By _____

1. **I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made with the Accounting Department.**
2. **AUTHORIZATION TO RELEASE INFORMATION: I herby authorize the release of any information regarding my/my child's condition or treatment to my insurance company.**
3. **AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.**

SIGNED (patient, or parent if patient is minor) _____ DATE: _____