

**ASSOCIATED COUNSELING PROFESSIONALS**

**CLIENT INFORMATION SHEET FOR MIKE STREETER**

Client Name _____	** Social Security # of <u>Insurance Card Holder</u>
E-Mail Address _____	** _____

Address _____	City _____	State _____	Zip Code _____
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Home Phone Number _____	Work Phone Number _____	Cell Phone Number _____	Gender M F	Age _____	Date of Birth ____/____/____
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Check One: <input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Married	Is it ok to contact you at home?	Yes	No
<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other	Is it ok to contact you at work?	Yes	No

Your Employer or School _____	Your Social Security Number _____
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Name of Spouse (or Parent) _____	Date of Birth _____	CHECK ONE:	<input type="checkbox"/> Employed
		<input type="checkbox"/> Part-Time Student	<input type="checkbox"/> Full -Time Student

In Case of Emergency, Notify _____	Phone Number _____
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Physician Name _____	Medication You Are Taking _____
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**INSURANCE INFORMATION**

Insured's Name _____	Insured's Social Security Number _____
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Address _____	City _____	State _____	Zip Code _____
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Home Phone Number _____	Work Phone Number _____	Cell Phone Number _____	Gender _____	Date of Birth _____
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Insured's Employer or School _____	Check One:	<input type="checkbox"/> Employed
	<input type="checkbox"/> Part-Time Student	<input type="checkbox"/> Full-Time Students

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**FOR OFFICE USE: DO NOT WRITE BELOW THIS LINE**

Benefits –

INSURANCE COMPANY \_\_\_\_\_

Deductible \$ \_\_\_\_\_

Co-pay \$ \_\_\_\_\_

Self Pay - Yes No (circle)

Number of Sessions - \_\_\_\_\_/year

Authorization Needed - Yes \_\_\_\_\_ No \_\_\_\_\_

**MIKE STREETER:**

**DSM CODE:** \_\_\_\_\_

**ACCT. #** \_\_\_\_\_

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**CONSENT TO TREATMENT/CONFIDENTIALITY STATEMENT**

I, (print name) \_\_\_\_\_ consent for treatment to be rendered by Mike Streeter, APRN of Associated Counseling Professionals. I grant authority to Mike Streeter, APRN to perform those procedures and treatments that are necessary for my condition that are generally used in this and similar settings.

I understand that information or opinions will be given to others only with my written consent, with the exception that: When there is reason to believe that if a client threatens harm to himself or herself or others, the law requires that a report be made. If there is a possibility of danger to a client or others due to a client's history, a report may need to be made.

**SIGNED BY CLIENT**

**DATE:**

X \_\_\_\_\_

X \_\_\_\_\_