Better Solutions Counseling Center

FOR OFFICE USE ONLY
DX CODE(S): _____
ACCT #: BSCC_____

New Client Information Sheet

Please complete all information.

Client Name: _____ Date of Birth: _____ Age: _____

Today's Date: _____ Referral Source: _____

Social Security Number: _____ Email Address: _____

Telephone Number: _____ Cell Phone Number: _____ Would you like text message appointment reminders? ☐ YES ☐ NO

Mailing Address: _____
STREET/P.O. BOX CITY STATE ZIP

Physical Address: _____
STREET CITY STATE ZIP

Emergency Contact Name: _____ Relationship: _____

Telephone Number: _____ Cell Phone Number: _____

Mailing Address: _____
STREET/P.O. BOX CITY STATE ZIP

Insurance Company: _____ Policy #: _____ Group#: _____

Mailing Address: _____
STREET/P.O. BOX CITY STATE ZIP

Policy Holder's:

Name: _____ Date of Birth: _____ Social Security Number: _____

Medicaid Number: _____ State if not Wyoming: _____

Client/Guarantor Signature: _____ Date: _____

Client/Guardian Initial _____ ☐ Reviewed Consent to Treat and signed

Client/Guardian Initial _____ ☐ Reviewed Client Payment Agreement and signed

Client/Guardian Initial _____ ☐ Reviewed Client Confidentiality & Notice of Privacy and Understands

Client/Guardian Initial _____ ☐ Reviewed Client Rights (HIPAA)

Therapist Signature: _____ Date: _____