Counseling Request Form

Client Name: _____
First Last

Address: _____
Street City/Town Zip code

DOB: ___/___/____

If applicable, parent or guardian: _____

Contact Phone: (_____)_____-_____ **Circle one: Mobile or Landline**

Primary Insurance Name: _____ **Member ID #:** _____

Secondary Insurance Name: _____ Member ID #: _____

*****You are responsible for contacting Member Services on the back of your insurance card to confirm in-network as well as copay and/or deductible payment due before each visit *****

When are you available for appointments? (Circle all that apply)

Morning Mid-Day Evening Anytime

Mon Tue Wed Thur Fri Sat

Types and Topics (Circle all that apply) INDIVIDUAL

COUPLES FAMILY ANXIETY DEPRESSION LOSS TRAUMA

ILLNESS DIVORCE ANGER MANAGEMENT SUBSTANCES DOMESTIC VIOLENCE OTHER

********** OFFICE USE ONLY BELOW THIS LINE**********

Today's Date: ___/___/2021 Provider: ___ Ins.Subscriber:_____DOB:_____

Ins ID#: _____ EAPs: Y N Auth#: Sessions#

Insurance Benefits:

Effective Date: CoPay: $ CoIns: % Sessions per year:_____

Deductible: Ind $ .00 Fam $ .00 Met / Not Met_____

Requirements: Authorization or No authorization

Auth #_____ Start date / / End date / / Sessions#___

Benefit Year: 1-1 to 12-31 7-1 to 6-30 10-1 to 9-30

Date & Time 1st Appt:

___/___/2021

____:_____

Am Pm

Any therapy in the last year? **Y N**

Has Pt been in TX in the past year? **Y N**

Bringing a List of Medications? **Y N**